068516 OCT 14 '87

4

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director page 3 should be detached for use as the burial-transit permit. Then please check carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified and

BP_____

DHMH – 16 60M 7/84
(VRA 15, 4)

FOR STATE REGISTRAR

**STATE OF MARYLAND**
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**
**CERTIFICATE OF DEATH**

REG. NO. 87 29553

| | | | | |
|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) First: Concetta Middle: Cestone Last: Alongi | | | 2a. DATE OF DEATH Month Day Year: October 8,1987 | 2b. HOUR: 6:56 A.M. |
| 3. SEX: Female | 4. RACE: Caucasian | 5. DATE OF BIRTH Month Day Year: 2-28-1898 | 6. AGE (IN YEARS LAST BIRTHDAY): 89 YRS. | If under 1 year: Months / Days; If under 24 hrs.: Hours / Min. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Italy | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: Charles County, MD | |
| 10. CITY OR TOWN OF DEATH: LaPlata | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Physicians Memorial Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Housewife. | 12b. KIND OF BUSINESS OR INDUSTRY: Home |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS / ZIP CODE |
|---|---|---|---|---|
| Maryland | Charles | La Plata | YES ☐ NO ☒ | RR 2 Box 2364E/ 20646 |

| 14. FATHER'S NAME First / Middle / Last | 15. MOTHER'S MAIDEN NAME First / Middle / Last |
|---|---|
| Joseph Cestone | unavailable |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| no | --- | 219-46-5971 | Jeanette A. Barbour - same as # 13 | |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b) and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIO RESPIRATORY FAILURE
DUE TO, OR AS A CONSEQUENCE OF (b) ACUTE PULMONARY EDEMA
DUE TO, OR AS A CONSEQUENCE OF (c) CARDIOMEGALY AND CONGESTIVE HEART FAILURE
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): RECENT MYOCARDIAL INFARCTION.

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES ☐ NO ☒ | YES ☐ NO ☐ |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) |
|---|---|---|
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |

22a. **I certify** that (I) (this hospital) attended the deceased from 10-8- 19 87 to 10-8- 19 87 that (I) (we) last saw the deceased alive on 10-8- 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| V. Ammangandla | ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 10-8-87 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| Ammangandla Sagar M.D. | P.O. Box 282 Charlotte Hall, MD. 20632 |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / STATE |
|---|---|---|---|
| BURIAL | 10-13-87 | Arlington Cem | Arlington VA |

| 24. FUNERAL DIRECTOR NAME | ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| Huntt Funeral Home | P. O. box 156 Waldorf, Md. 20601 | OCT 13 1987 | Julia Davidson-Rowe |

071017 NOV -6 1987 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO 29554

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon sheets. Pages 1 and 2 are to be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, an other traumatic event, the medical examiner must be notified before any disposition of remains.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: ELVA | MIDDLE: M. | LAST: ARTES | 2a. DATE OF DEATH MONTH: October | DAY: 31 | YEAR: 1987 |
| 2b. HOUR: 7:30P M | | | | | |
| 3. SEX: Female | 4. RACE: Caucasian | 5. DATE OF BIRTH MONTH: April | DAY: 2 | YEAR: 1896 | 6. AGE (IN YEARS LAST BIRTHDAY): 91 YRS. |
| IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 1 DAY: HOURS / MIN. | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Washington, D. C. | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: Charles MD | | |
| 10. CITY OR TOWN OF DEATH: La Plata | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NEITHER, GIVE STREET ADDRESS): Physicians Memorial Hospital | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Housewife | 12b. KIND OF BUSINESS OR INDUSTRY: N/A | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | |
| 13a. STATE: Maryland | 13b. COUNTY: Charles | 13c. CITY OR TOWN: Waldorf | 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ | 13e. STREET ADDRESS / ZIP CODE: 2602 Ferguson Court 20601 | |
| 14. FATHER'S NAME FIRST: Lexious | MIDDLE | LAST: Wood | 15. MOTHER'S MAIDEN NAME FIRST: Elizabeth | MIDDLE: L. | LAST: Cook |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO.: 577-84-3424 | 17. INFORMANT: Thelma E. Ford | ADDRESS: 2602 Ferguson Ct. Waldorf, Md. | | |

**MEDICAL CERTIFICATION**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardiorespiratory Arrest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☒ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN EITHER PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE | |

22a. I certify that (I) XXXXXX attended the deceased from 1/17/ 19 85 to 10/31/87 19 ____ that (I) (We) last saw the deceased alive on 10/13 19 87 and that in my (X) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) XXX view the body after death.

| | | | |
|---|---|---|---|
| 22b. SIGNATURE: A Stephan Hansman | DEGREE: ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐ | 22c. DATE SIGNED: 11/2/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT): A.Stephan Hansmam,M.D. | 22e. ADDRESS: Penbrooke Sq.Waldorf,Md. 20601 | | |

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial | 23b. DATE: 11/4/87 | 23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery | 23d. LOCATION CITY OR TOWN: Suitland | COUNTY: P.G. STATE: Maryland |
| 24. FUNERAL DIRECTOR NAME: George P. Kalas Funeral Home | ADDRESS: 6160 Oxon Hill Rd. Oxon Hill, Md. | 25a. DATE REC'D. BY REGISTRAR: NOV 5 1987 | 25b. REGISTRAR'S SIGNATURE | |

BP ____

DHMH - 16 60M 7/84
(VRA 15, 4)

069036 OCT 20 87

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO 29555

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
**TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST | GEORGE | FREDERICK | AUFRECHT, JR. | 2a. DATE OF DEATH KNOWN X / ESTIMATED ☐ MONTH / DAY / YEAR | 10 | 13 1987 | 2b. HOUR M |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH / DAY / YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YR. MONTHS / DAYS | IF UNDER 24 HRS. HOURS / MIN | 2c. DATE PRONOUNCED DEAD MONTH / DAY / YEAR | | 2d. HOUR |
| Male | Cau. | 03-25-1936 | 51 YRS. | | | 10 | 13 1987 | 12:27 A M |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED X / NEVER MARRIED ☐ / WIDOWED ☐ / DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| Washington D.C. | U.S.A. | | Charles County MD | | | | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12. OCCUPATION (KIND OF WORK DONE DURING MOST OF WORKING LIFE) | KIND OF BUSINESS OR INDUSTRY | | | | | |
| La Plata | Physicians Memorial Hospital | SECURITY SYSTEMS REPAIRMAN | U.S. Gov't. | | | | | |

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS | |
|---|---|---|---|---|---|
| Maryland | Anne Arundel | Laurel | YES X NO ☐ | 243 Red Clay Rd., #201 | 20707 |

| 14. FATHER'S NAME FIRST / MIDDLE / LAST | 15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST |
|---|---|
| George Frederick Aufrecht, Sr. | Helen Gladys |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|
| Yes Korean | 579-46-4504 | Rose Marie Aufrecht, Same as Line #13 |

**MEDICAL CERTIFICATION**

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Neck injuries | |
| DUE TO, OR AS A CONSEQUENCE OF (b) | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | |

Conditions, if any, which gave rise to immediate couse (a) stating the underlying couse last

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? |
|---|---|---|
| | | YES X NO ☐ |

| 21a. EXTERNAL CAUSE WAS | 21b. TIME OF INJURY HOUR / MONTH / DAY / YEAR | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) |
|---|---|---|
| UNDERLYING X OR CONTRIBUTING ☐ CAUSE OF DEATH | 11:17 A.M. 10-12-1987 | Driver of pick-up truck/fixed object impact. |

| 21d. INJURY OCCURRED | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |
|---|---|---|
| WHILE AT WORK ☐ NOT WHILE AT WORK X | road | Middletown Rd. off Rt. 227 / Charles / MD |

22a. I certify that I took charge of the remains described above, held an Autopsy X, Inspection ☐, Inquiry ☐, and in my opinion deoth resulted from: Natural couses ☐, Accident X, Suicide ☐, Homicide ☐, Undetermined monner ☐

ACTUAL SIGNATURE [signature] M.D. TITLE (SPECIFY) Assistant MEDICAL EXAMINER DATE SIGNED 10-14-87

EXAMINER'S NAME (TYPE OR PRINT) Mario F. Golle, Jr., M.D. ADDRESS 111 Penn St., Balto., MD 21201

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| Burial | 10-16-87 | Md. Veterans Cemetery | Cheltenham, P.G., Maryland |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. DATE REC'D BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| FRANCIS GASCHS SONS FUNERAL HOME, P.A. 4739 Baltimore Ave., Hyattsville, Maryland | OCT 19 1987 | [signature] |

07-84 25M BP

DHMH - 17 (VR A15 ME (5))

70614 NOV -3 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG NO 87 2956

1. DECEASED NAME (TYPE OR PRINT): First: Sylvia Middle: Lorraine Last: Baird

2a. DATE OF DEATH (Month Day Year): 10/30/87

2b. HOUR: 5:21 am

3. SEX: Female

4. RACE: Caucasian

5. DATE OF BIRTH (Month Day Year): 4-16-1932

6. AGE (In years last birthday): 55 YRS

7a. BIRTHPLACE (State or foreign country): West Virginia

7b. CITIZEN OF WHAT COUNTRY?: USA

8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

9. BALTIMORE CITY OR COUNTY OF DEATH: Charles MD

10. CITY OR TOWN OF DEATH: La Plata

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Physicians Memorial Hospital

12a. USUAL OCCUPATION (Type of work for most of working life): Housewife

12b. KIND OF BUSINESS OR INDUSTRY: Home

USUAL RESIDENCE (If nursing home or other institution, give residence before admission)

13a. STATE: Maryland

13b. COUNTY: Charles

13c. CITY OR TOWN: Waldorf

13d. INSIDE CITY LIMITS? YES [ ] NO [X]

13e. STREET ADDRESS / ZIP CODE: 134 Garner Ave./20601

14. FATHER'S NAME: First: Madison Middle: Earl Last: Eakle

15. MOTHER'S MAIDEN NAME: First: Mary Middle: Alice Last: Demastus

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): no

(IF YES, GIVE WAR OR DATES): --

16b. SOCIAL SECURITY NO: 234-44-0536

17. INFORMANT: Samuel Baird ADDRESS: same as # 13

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for a, b, and c.)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): CARDIAC ARREST

DUE TO, OR AS A CONSEQUENCE OF (b): ISCHAEMIC CARDIOMYOPATHY

DUE TO, OR AS A CONSEQUENCE OF (c): CORONARY ARTERY DISEASE

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Chronic Renal Failure; Diabetes Mellitus, Peripheral Neuropathy

19a. DATE OF OPERATION:

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20a. AUTOPSY? YES [ ] NO [X]

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT, WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY (Hour A.M. P.M. Month Day Year 19):

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2):

21d. INJURY OCCURRED: While at work [ ] Not while at work [ ]

21e. PLACE OF INJURY (At home, street, factory, office, farm, etc.):

21f. LOCATION (Street, City or town, County, State):

22a. I certify that I (this hospital) attended the deceased from 10/20/87 19__ to 10/30/87 19__ that I (we) last saw the deceased alive on 10/29/87 19__ and that in my (our) opinion death occurred on the date and hour and from the causes stated above. I (we) did (did not) view the body after death.

22b. SIGNATURE: Sanjeeb Mishra DEGREE: ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]

22c. DATE SIGNED: 10/30/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Sanjeeb Mishra , MD

22e. ADDRESS: 506 Chestnut ct. La Plata, Md. 2064

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 11-2-87

23c. NAME OF CEMETERY OR CREMATORY: Trinity Mem. Gardens

23d. LOCATION (City or town, State): Waldorf, Charles, Md.

24. FUNERAL DIRECTOR (NAME): Huntt Funeral Home ADDRESS: P. O. Box 156 Waldorf, Md. 20601

25a. DATE REC'D BY REGISTRAR: NOV 2 1987

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Landrey

IMPORTANT: If Item 21 is marked or Item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached to use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP_____

DHMH - 16 60M 7-84
(VRA 15, 4)

3

069652 OCT 26 87

FOR 1 - STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

87 29557

REG. NO

| 1. DECEASED NAME (TYPE OR PRINT) FIRST | MIDDLE | LAST | 2a. DATE OF DEATH MONTH DAY YEAR | 2b. HOUR |
|---|---|---|---|---|
| Mazie | E | Barnes | October 15, 1987 | 4:15 P M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS HOURS MIN. |
|---|---|---|---|---|---|
| FEMALE | BLACK | 12- 15- 1908 | 78 YRS | | |

| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH |
|---|---|---|---|
| WASHINGTON, DC | UNITED STATES | | Charles MD |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| La Plata | Physicians Memorial Hosptial | NURSE AIDE | PRIVATE |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS / ZIP CODE |
|---|---|---|---|---|
| MARYLAND | CHARLES | PORTTOBACCO | YES ☐ NO ☒ | POOR HOUSE ROAD/ 20677 |

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| ROBERT | | SMITH | MATTIE | | JONES |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|---|
| NO | | 216-40-7846 | MATTIE BARNES PORT TOBACCO, MARYLAND BOX 1153 |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Cardiopulmonary arrest | 6 min |
| DUE TO, OR AS A CONSEQUENCE OF (b) | Liver failure | 1 month |
| DUE TO, OR AS A CONSEQUENCE OF (c) | colon cancer, liver metastases | 1 yr |

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I a

Coronary artery disease, anemia 2° nasal gastric bleeding

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| N/A | N/A | YES ☐ NO ☒ | YES ☐ N/A NO ☐ |

| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART II) |
|---|---|---|
| N/A ☐ | N/A | N/A |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET | CITY OR TOWN | COUNTY | STATE |
|---|---|---|---|---|---|
| N/A | N/A | N/A | | | |

22a. I certify that (I) (this hospital) attended the deceased from 10/11 19 87 to 10/15 19 87 that (I) (we) last saw the deceased alive on 10/14 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| Paul E Pritchett MD | ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 10/15/87 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| Paul E Pritchett M.D | La Plata, Maryland 20646 |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN | COUNTY | STATE |
|---|---|---|---|---|---|
| BURIAL | 10-19-87 | ST. CATHERINE'S | McCONCHIE | CHARLES | MD. |

| 24. FUNERAL DIRECTOR NAME | ADDRESS | 25a. DATE REC'D BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| THORNTON FUNERAL HOME | POMONKEY, MD. | OCT 21 1987 | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please complete and forward pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked, or there is known any injury, or other circumstances, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

070044 OCT 28 87 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO 29568

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed ... hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: JAMES | MIDDLE: WESLEY | LAST: BATTLE, JR. | 2a. DATE OF DEATH MONTH DAY YEAR: October 24, 1987 | 2b. HOUR: 5:15A M | |
| 3. SEX: Male | 4. RACE: Caucasian | 5. DATE OF BIRTH MONTH DAY YEAR: May 27, 1936 | 6. AGE (IN YEARS LAST BIRTHDAY): 51 YRS | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Washington, DC | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED XX NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: Charles MD | | |
| 10. CITY OR TOWN OF DEATH: Waldorf | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 508 Garner Ave. | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Audit Chief | 12b. KIND OF BUSINESS OR INDUSTRY: Vet. Adm. | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland | 13b. COUNTY: Charles | 13c. CITY OR TOWN: Waldorf | 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ | 13e. STREET ADDRESS / ZIP CODE: 508 Garner Ave. / 20601 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST: James Wesley Battle, Sr. | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST: Helen Bachelor | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): Yes | (IF YES, GIVE WAR OR DATES): 1959-1961 | 16b. SOCIAL SECURITY NO.: 577-46-5281 | 17. INFORMANT ADDRESS: Joyce A. Battle (Spouse) -Same as13 | | |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a): Cardiopulm. arrt

DUE TO, OR AS A CONSEQUENCE OF (b): Carcinoma of the

DUE TO, OR AS A CONSEQUENCE OF (c): Appendix & metastasis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO XX | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |

| | | | |
|---|---|---|---|
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE | |

22a. I certify that (I) (~~the coroner~~) attended the deceased from 10-10 19 86 to 9-20 19 87 that (I) (~~we~~) last saw the deceased alive on 9-20 19 87, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~we~~) (did) (did not) view the body after death.

| | | | |
|---|---|---|---|
| 22b. SIGNATURE: K. Kancer-Azer | DEGREE: ATTENDING PHYSICIAN XX MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 22c. DATE SIGNED: 10/25/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT): Kancer Azer, M.D. | 22e. ADDRESS: 9131 Piscataway Rd. Clinton, Md. | | |

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Cremation | 23b. DATE: 10/25/87 | 23c. NAME OF CEMETERY OR CREMATORY: Huntt Crematorium | 23d. LOCATION CITY OR TOWN / COUNTY / STATE: Waldorf, Charles, Md. | |
| 24. FUNERAL DIRECTOR NAME / ADDRESS: Huntt Funeral Home | P.O. Box 156 Waldorf, Md 20601 | 25a. DATE REC'D. BY REGISTRAR: OCT 27 1987 | 25b. REGISTRAR'S SIGNATURE: [signature] | |

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

071294 NOV 10 87

FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

87 29559
REG. NO

1. DECEASED NAME (TYPE OR PRINT): FIRST Benjamin MIDDLE Tyler LAST Bowling
2a. DATE OF DEATH: MONTH 10 DAY 26 YEAR 87
2b. HOUR: 7:27 PM
3. SEX: M
4. RACE: Cauc
5. DATE OF BIRTH: MONTH 1 DAY 21 YEAR 07
6. AGE (IN YEARS LAST BIRTHDAY): 80 YRS
IF UNDER 1 YEAR: MONTHS / DAYS
IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MD.
7b. CITIZEN OF WHAT COUNTRY? USA
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
9. BALTIMORE CITY OR COUNTY OF DEATH: Charles MD
10. CITY OR TOWN OF DEATH: La Plata
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Route Six
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Farm
12b. KIND OF BUSINESS OR INDUSTRY: Farming

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: MD
13b. COUNTY: Charles
13c. CITY OR TOWN: Charlotte Hall
13d. INSIDE CITY LIMITS? YES ☐ NO ☑
13e. STREET ADDRESS / ZIP CODE: RT 1 - Box 202 Charlotte Hall MD 20622

14. FATHER'S NAME: FIRST Robert MIDDLE Pope LAST Bowling
15. MOTHER'S MAIDEN NAME: FIRST Estelle MIDDLE Hurley LAST Bowling
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No
(IF YES, GIVE WAR OR DATES)
16b. SOCIAL SECURITY NO: 217-36-7531
17. INFORMANT: Jean B. Barbour, ADDRESS Box 63 La Plata, Md. 20646

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Respiratory Failure
DUE TO, OR AS A CONSEQUENCE OF (b): Chronic Obstructive Pulmonary Disease
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a): Atherosclerotic Heart Disease,

19a. DATE OF OPERATION:
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20a. AUTOPSY? YES ☐ NO ☑
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART II)
21d. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION: STREET, CITY OR TOWN, COUNTY, STATE

22a. I certify that (I) (this hospital) attended the deceased from _____ 19____ to 10-26 19 87 that (I) (we) last saw the deceased alive on 10-26 19 87, and that in (my) (our) opinion death occurred at the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Henry L Burke MD
DEGREE: ATTENDING PHYSICIAN ☑ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐
22c. DATE SIGNED: 10-26-87
22d. PHYSICIAN'S NAME (TYPE OR PRINT): Henry L. Burke, M.D.
22e. ADDRESS: La Plata, Maryland 20646

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
23b. DATE: 10/29/87
23c. NAME OF CEMETERY OR CREMATORY: Trinity Episcopal
23d. LOCATION: CITY OR TOWN Newport, COUNTY Charles, STATE Md.

24. FUNERAL DIRECTOR NAME AND ADDRESS: Arehart Funeral Home, Inc. La Plata
25a. DATE REC'D. BY REGISTRAR: NOV 12 1987
25b. REGISTRAR'S SIGNATURE: Barbara Davidson Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remit the certificate, with pages 1 and 2 to the Registrar. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

071062 NOV 6 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 29560

DECEASED NAME (TYPE OR PRINT): FIRST ANDREA; MIDDLE D.; LAST BOWMAN

2a. DATE OF DEATH: KNOWN X, ESTIMATED ☐ — 10-26-19 87 — 2b. HOUR

3. SEX: FEMALE | 4. RACE: BLACK | 5. DATE OF BIRTH: 11-26-85 | 6. AGE (IN YEARS LAST BIRTHDAY): 1 YRS. | IF UNDER 1 YR: MONTHS, DAYS | IF UNDER 24 HRS: HOURS, MIN.

2c. DATE PRONOUNCED DEAD: 10-26-19 87 — 2d. HOUR: 1:32 PM

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MARYLAND

7b. CITIZEN OF WHAT COUNTRY?: UNITED STATES

8. MARRIED ☐ NEVER MARRIED X WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Charles County MD

10. CITY OR TOWN OF DEATH: La Plata

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Physicians Memorial Hospital (DOA)

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): N/A

12b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: MARYLAND | 13b. COUNTY: CHARLES | 13c. CITY OR TOWN: POMFRET | 13d. INSIDE CITY LIMITS? YES ☐ NO X | 13e. STREET ADDRESS: ROUTE 227/ 20675

14. FATHER'S NAME: FIRST ARTHUR; MIDDLE D.; LAST BOWMAN

15. MOTHER'S MAIDEN NAME: FIRST PATRICIA; MIDDLE; LAST MUSCHETTE

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): NO | (IF YES, GIVE WAR OR DATES):

16b. SOCIAL SECURITY NO.: N/A

17. INFORMANT: PATRICIA BOWMAN — ADDRESS: BOX 124 Rt. 227 POMFRET, MD.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Smoke and soot inhalation

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b):

DUE TO, OR AS A CONSEQUENCE OF (c):

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a.

19a. DATE OF OPERATION:

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?:

20. AUTOPSY? YES X NO ☐

21a. EXTERNAL CAUSE WAS UNDERLYING X OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR: 10 xxx 10-26-19 87

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2): House fire.

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK X

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.): home

21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE: P.O. Box 227, Box 124, Holly Springs Rd. Nanjemoy, Charles, MD

22a. I certify that I took charge of the remains described above; held an Autopsy X Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural causes ☐ Accident X Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Charles P. Kokes M.D. TITLE (SPECIFY): Assistant MEDICAL EXAMINER — DATE SIGNED: 10-27-87

EXAMINER'S NAME (TYPE OR PRINT): Charles P. Kokes, M.D. — ADDRESS: 111 Penn St., Balto., MD 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL | 23b. DATE: 10-29-87 | 23c. NAME OF CEMETERY OR CREMATORY: ST. JOSEPH | 23d. LOCATION CITY OR TOWN / COUNTY / STATE: POMFRET CHARLES MD.

24. FUNERAL DIRECTOR NAME / ADDRESS: THORNTON FUNERAL HOME POMONKEY, MD.

25a. DATE REC'D BY REGISTRAR: NOV 02 1987 — 25b. REGISTRAR'S SIGNATURE: Julia Davidson-Payne

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITH ALL POSSIBLE DISPATCH AND FILED WITHIN 72 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18 AND GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGES 5 FOR YOUR FILES.
**TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201, PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84 25M BP

DHMH - 17 (VR A15 ME (5))

071063 NOV-6 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR — REG. NO. 29561

1. DECEASED NAME (TYPE OR PRINT): FIRST JOSETTE; MIDDLE L.; LAST BOWMAN
2a. DATE OF DEATH: KNOWN [X] ESTIMATED [ ] MONTH 10 DAY 26 YEAR 1987
2b. HOUR: M
3. SEX: FEMALE
4. RACE: BLACK
5. DATE OF BIRTH: MONTH 12 DAY 08 YEAR 86
6. AGE (IN YEARS LAST BIRTHDAY): YRS.
IF UNDER 1 YR: MONTHS 10 DAYS
IF UNDER 24 HRS: HOURS MIN
2c. DATE PRONOUNCED DEAD: MONTH 10 DAY 26 YEAR 87
2d. HOUR: 1:32 P M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MARYLAND
7b. CITIZEN OF WHAT COUNTRY?: UNITED STATES
8. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]
9. BALTIMORE CITY OR COUNTY OF DEATH: Charles County MD
10. CITY OR TOWN OF DEATH: La Plata
11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Physicians Memorial Hospital (DOA)
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): N/A
12b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: MARYLAND
13b. COUNTY: CHARLES
13c. CITY OR TOWN: POMFRET
13d. INSIDE CITY LIMITS? YES [ ] NO [X]
13e. STREET ADDRESS: ROUTE 227/ 20675

14. FATHER'S NAME: FIRST ARTHUR; MIDDLE D.; LAST BOWMAN
15. MOTHER'S MAIDEN NAME: FIRST PATRICIA; MIDDLE; LAST MUSCHETTE
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): NO
(IF YES, GIVE WAR OR DATES):
16b. SOCIAL SECURITY NO.: N/A
17. INFORMANT: PATRICIA BOWMAN
ADDRESS: BOX 124 Route 227 POMFRET, MARYLAND

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Smoke and soot inhalation
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b):
DUE TO, OR AS A CONSEQUENCE OF (c):
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):

19a. DATE OF OPERATION:
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?:
20. AUTOPSY? YES [X] NO [ ]

21a. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH
21b. TIME OF INJURY HOUR A.M. MONTH 10 DAY 26 YEAR 1987
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2): House fire.
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.): house
21f. LOCATION STREET: P.O. Box 227, Box 124, Holly Springs Rd. CITY OR TOWN: Nanjemoy COUNTY: Charles STATE: MD

22a. I certify that I took charge of the remains described above and on Autopsy [X] Inspection [ ] Inquiry [ ] and in my opinion death resulted from: Natural causes [ ] Accident [X] Suicide [ ] Homicide [ ] Undetermined manner [ ]

ACTUAL SIGNATURE: Charles P. Kokes M.D.
TITLE (SPECIFY): M.D. Assistant MEDICAL EXAMINER
DATE SIGNED: 10-27-87
EXAMINER'S NAME (TYPE OR PRINT): Charles P. Kokes, M.D.
ADDRESS: 111 Penn St., Balto., MD 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL
23b. DATE: 10-29-87
23c. NAME OF CEMETERY OR CREMATORY: ST. JOSEPH
23d. LOCATION CITY OR TOWN: POMFRET COUNTY: CHARLES STATE: MD.

24. FUNERAL DIRECTOR NAME AND ADDRESS: THORNTON FUNERAL HOME POMFRET, MD.
25a. DATE REC'D BY REGISTRAR: NOV 02 1987
25b. REGISTRAR'S SIGNATURE:

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR ALONG WITH FORM PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION OR REMOVAL.
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84 25M BP
DHMH - 17 (VR A15 ME (5))

5

068495 OCT 14 87

FOR 1 - STATE REGISTRAR

# STATE OF MARYLAND
# DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO 87 29562

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then the remaining carbon papers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, poisoning or complication of a traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 60M 7-84 (VRA 15, 4)

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) — FIRST / MIDDLE / LAST | Mary Evelyn Butler | | | 2a. DATE OF DEATH — MONTH / DAY / YEAR | October 04 1987 |
| | | | | 2b. HOUR | 1:48 AM |
| 3. SEX | FEMALE | 4. RACE | BLACK | 5. DATE OF BIRTH — MONTH / DAY / YEAR | May 5 1928 |
| 6. AGE (IN YEARS LAST BIRTHDAY) | 59 YRS | IF UNDER 1 YEAR — MONTHS / DAYS | | IF UNDER 24 HRS. — HOURS / MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | MARYLAND | 7b. CITIZEN OF WHAT COUNTRY? | UNITED STATES | 8. MARRIED X / NEVER MARRIED / WIDOWED / DIVORCED | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH | Charles MD | | | | |
| 10. CITY OR TOWN OF DEATH | La Plata | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | Physicians Memorial Hospital | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | COOK |
| 12b. KIND OF BUSINESS OR INDUSTRY | PRIVATE | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE | MARYLAND | 13b. COUNTY | CHARLES | 13c. CITY OR TOWN | ROCK POINT |
| 13d. INSIDE CITY LIMITS? | YES / NO X | 13e. STREET ADDRESS / ZIP CODE | GENERAL DELIVERY/ 20682 | | |
| 14. FATHER'S NAME — FIRST / MIDDLE / LAST | ARTHUR EDELEN | 15. MOTHER'S MAIDEN NAME — FIRST / MIDDLE / LAST | KATRINE MOORE | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | NO | (IF YES, GIVE WAR OR DATES) | | 16b. SOCIAL SECURITY NO. | 220-26-7144 |
| 17. INFORMANT — ADDRESS | GAIL BUTLER ROCK POINT, MARYLAND 20682 | | | | |

## MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** Enter only one cause per line for (a), (b), and (c).

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) Cardiac Arrest, Sudden Death — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DUE TO, OR AS A CONSEQUENCE OF (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Hypertension, Diabetes Mellitus

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES / NO | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES / NO |

| | | |
|---|---|---|
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY — HOUR A.M. P.M. / MONTH / DAY / YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART II) |
| 21d. INJURY OCCURRED — WHILE AT WORK / NOT WHILE AT WORK | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION — STREET / CITY OR TOWN / COUNTY / STATE |

22a. I certify that I (this hospital) attended the deceased from 3 19 85 to 7-12 19 87 that I (we) last saw the deceased alive on 19 87, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. I (we) did did not view the body after death.

22b. SIGNATURE — DEGREE: ATTENDING PHYSICIAN / MEDICAL DIRECTOR / STAFF PHYSICIAN — 22c. DATE SIGNED 10-7-87

| | |
|---|---|
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | Daniel Howell, M.D. |
| 22e. ADDRESS | Pennbrooke Sq.Waldorf, Maryland20601 |

| | | | |
|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | BURIAL | 23b. DATE | 10-7-87 |
| 23c. NAME OF CEMETERY OR CREMATORY | HOLY GHOST | 23d. LOCATION — CITY OR TOWN / COUNTY / STATE | ISSUE CHARLES MD. |
| 24. FUNERAL DIRECTOR (NAME) | THORNTON FUNERAL HOME | ADDRESS | POMONKEY, MD. |
| 25a. DATE REC'D BY REGISTRAR | OCT 08 1987 | 25b. REGISTRAR'S SIGNATURE | |

70609 NOV -3 87 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO B/ 29563

| 1. DECEASED NAME (TYPE OR PRINT) FIRST | MIDDLE | LAST | 2a. DATE OF DEATH MONTH DAY YEAR | 2b. HOUR |
|---|---|---|---|---|
| William | A | Campbell | October 23, 1987 | 5:19PM |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. |
|---|---|---|---|---|---|
| male | Black | October 6, 1915 | 72 YRS. | | |

| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED | 9. BALTIMORE CITY OR COUNTY OF DEATH |
|---|---|---|---|
| Maryland | USA | MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | Charles MD |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| La Plata | Physicians Memorial Hospital | | |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES / NO | 13e. STREET ADDRESS / ZIP CODE |
|---|---|---|---|---|
| Maryland | Charles | La Plata | YES XX NO [ ] | Bldg 610 - B Rte. 4 Zekiah Run Rd. 20646 |

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| James | N. | Campbell | Frances | L. | Chesley |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| unknown | | 213 22 0955 | Margaret Campbell | SAA |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardiac arrest-

DUE TO, OR AS A CONSEQUENCE OF (b) Cerebrovascular Accident

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Emphysema.

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES / NO | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES / NO |
|---|---|---|---|
| | | YES [ ] NO [ ] | YES [ ] NO [ ] |

| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |
|---|---|---|
| [ ] | | |

| 21d. INJURY OCCURRED WHILE AT WORK / NOT WHILE AT WORK | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |
|---|---|---|
| [ ] [ ] | | |

22a. I certify that (I) (this hospital) attended the deceased from ~~May~~ 19 81 to 10-23- 19 87 that (I) ~~was~~ last saw the deceased alive on 10-23- 19 87 and that (to) (my) ~~(did) (did not)~~ opinion death occurred on the date and hour and from the causes stated above. (I) ~~was~~ (did) ~~(did not)~~ view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| [signature] | M.D. ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [X] STAFF PHYSICIAN [ ] | |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| Girija S. Rath, M.D. | La Plata, Maryland |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| Burial | 28 Oct 87 | St Mary's Cath Ch | Newport, Chas.Co., MD |

| 24. FUNERAL DIRECTOR NAME | ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| Martell Adams | Aquasco Md 20608 | NOV 2 1987 | [signature] |

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours. Page 4 may be retained by the hospital or attending physician.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

070923 NOV-5 87

FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO 87 29564

1. DECEASED NAME (TYPE OR PRINT): FIRST ROSIE MIDDLE Rose LAST Lee CHAPMAN
2a. DATE OF DEATH: MONTH 10 DAY 20 YEAR 87
2b. HOUR 3:25 A M
3. SEX: Female
4. RACE: BLACK
5. DATE OF BIRTH: MONTH FEB DAY 13 YEAR 1902
6. AGE (IN YEARS LAST BIRTHDAY): 85 YRS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): WASHINGTON DC.
7b. CITIZEN OF WHAT COUNTRY? USA
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
9. BALTIMORE CITY OR COUNTY OF DEATH: CHARLES County MD
10. CITY OR TOWN OF DEATH: LA PLATA
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): MERIDIAN NURSING CENTER
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): RETIRED
12b. KIND OF BUSINESS OR INDUSTRY:
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: MARYLAND
13b. COUNTY: CHARLES
13c. CITY OR TOWN: NANJEMOY
13d. INSIDE CITY LIMITS? YES ☐ NO ☐
13e. STREET ADDRESS / ZIP CODE: RT 1 BOX 104-D 20662
14. FATHER'S NAME: FIRST PETER MIDDLE LAST Cunningham
15. MOTHER'S MAIDEN NAME: FIRST SARAH MIDDLE LAST BROWN
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO (IF YES, GIVE WAR OR DATES)
16b. SOCIAL SECURITY NO: 579-30-4984
17. INFORMANT: Charles Chapman ADDRESS: 3626 Mt. Ash Ct Waldorf, Maryland 20601

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for a, b, and c.)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Infection with Septicemia — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral Vascular Accident
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last
DUE TO, OR AS A CONSEQUENCE OF (c) Senile Dementia
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I a

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES ☐ NO ☑
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) ☐
21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART II)
21d. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION: STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 4/15 19 86 to 10/20 19 87 that I (we) last saw the deceased alive on 9/23 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. I (we) (did) (did not) view the body after death.
22b. SIGNATURE: [signature] DEGREE: ATTENDING PHYSICIAN ☑ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐
22c. DATE SIGNED: 10/26/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT): GEORGE H WATHEN
22e. ADDRESS: LA PLATA, MD 20646

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL
23b. DATE: 10-24-87
23c. NAME OF CEMETERY OR CREMATORY: OAK GROVE BAPTIST
23d. LOCATION: CITY OR TOWN GRAYTON COUNTY CHARLES STATE MD
24. FUNERAL DIRECTOR: NAME THORNTON FUNERAL HOME ADDRESS POMONKEY, MD
25a. DATE REC'D BY REGISTRAR: OCT 30 1987
25b. REGISTRAR: [signature]

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by you, it must be filed by the funeral director page 3 should be detached to use as the burial-transit permit. Then please forward the carbon-paper pages (1 and 2) to the local registrar. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 states any injury, or other traumatic event, the medical examiner must be notified before any action is taken.

BP_____

DHMH 16 60M 7/84
(VRA 15, 4)

069588 OCT 23 '87

FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: Anna MIDDLE: Lee LAST: L. Chappelear | | | | 2a. DATE OF DEATH MONTH DAY YEAR: 10-17-87 | 2b. HOUR: 9:10 P M |
| 3. SEX: Female | 4. RACE: W | 5. DATE OF BIRTH MONTH DAY YEAR: 2 3 1893 | | 6. AGE (IN YEARS LAST BIRTHDAY): 94 YRS | IF UNDER 1 YEAR MONTHS / DAYS; IF UNDER 1 DAY HOURS / MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Charles County | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐ | | 9. BALTIMORE CITY OR COUNTY OF DEATH: Charles MD | |
| 10. CITY OR TOWN OF DEATH: La Plata | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Charles County Nursing Home | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker | 12b. KIND OF BUSINESS OR INDUSTRY: Own Home |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: md | 13b. COUNTY: Charles | 13c. CITY OR TOWN: Waldorf | 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ | 13e. STREET ADDRESS / ZIP CODE: PO Box 4-C Montgomery Ln 20601 | |
| 14. FATHER'S NAME FIRST: Charles MIDDLE: P. LAST: Herbert | | | | 15. MOTHER'S MAIDEN NAME FIRST: Sophia MIDDLE: LAST: Swann | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No (IF YES, GIVE WAR OR DATES): -------- | 16b. SOCIAL SECURITY NO.: 578-01-0234 | 17. INFORMANT: Thomas L. Chappelear | ADDRESS: P.O.Box 203 White Plains, Md. 20695 | | |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Cardiopulmonary arrest | Comm |
| DUE TO, OR AS A CONSEQUENCE OF (b) | Congestive Heart failure | 30 day |
| DUE TO, OR AS A CONSEQUENCE OF (c) | Arteriosclerotic Heart disease | many yrs |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: pulmonary edema, pneumonia - resolving, CVA, OBS

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION: N/A | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: N/A | 20a. AUTOPSY? YES ☐ NO ☒ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ N/A NO ☐ |
| 21a. ACCIDENT, WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER): N/A | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19: N/A | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR II): N/A | |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ N/A WHILE NOT AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.): N/A | 21f. LOCATION STREET: N/A CITY OR TOWN: COUNTY: STATE: | |

22a. **I certify** that (I) (this hospital) attended the deceased from 2/17 19 87 to 10/17 19 87 that (I) (we) last saw the deceased alive on 10/16 19 87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| | | | |
|---|---|---|---|
| 22b. SIGNATURE: Paul Pritchett MD | DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 22c. DATE SIGNED: 10/17/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT): Paul Pritchett, MD | 22e. ADDRESS: Waldorf, Maryland 20601 | | |

| | | | |
|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial | 23b. DATE: Oct. 20, 1987 | 23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cem. | 23d. LOCATION CITY OR TOWN: Suitland, COUNTY: P.G., STATE: Maryland |
| 24. FUNERAL DIRECTOR NAME: Huntt Funeral Home | ADDRESS: P.O. Box 156 Waldorf, Md. 20601 | 25a. DATE REC'D. BY REGISTRAR: OCT 22 1987 | 25b. REGISTRAR'S SIGNATURE: Julie Gardner-Rhodes |

BP_____

DHMH – 16 60M 7/84
(VRA 15, 4)

071228 NOV -9 87

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO 29560

| | | | | |
|---|---|---|---|---|
| 1 DECEASED NAME (TYPE OR PRINT) FIRST: LEWIS MIDDLE: RALPH LAST: CLARY, JR. | | | 2a DATE OF DEATH MONTH DAY YEAR: OCTOBER 29, 1987 | 2b HOUR: 6:50 A M |
| 3 SEX: MALE | 4 RACE: WHITE | 5 DATE OF BIRTH MONTH DAY YEAR: 3-20-27 | 6 AGE (IN YEARS LAST BIRTHDAY): 60 YRS. | IF UNDER 1 YEAR: MONTHS DAYS; IF UNDER 24 HRS.: HOURS MIN. |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY): OHIO | 7b CITIZEN OF WHAT COUNTRY?: U.S.A. | 8 MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9 BALTIMORE CITY OR COUNTY OF DEATH: CHARLES MD. | |
| 10 CITY OR TOWN OF DEATH: LA PLATA | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): PHYSICIANS MEMORIAL HOSPITAL | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): RET. NAVY | 12b KIND OF BUSINESS OR INDUSTRY: U.S.GOVT. | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE: MD. | 13b COUNTY: CHARLES | 13c CITY OR TOWN: WALDORF | 13d INSIDE CITY LIMITS? YES [ ] NO [X] | 13e STREET ADDRESS: 188-2 MILL HILL ROAD 20601 |
| 14 FATHER'S NAME FIRST: LEWIS MIDDLE: RALPH LAST: CLARY | | 15 MOTHER'S MAIDEN NAME FIRST: GRACE MIDDLE: LAST: | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): YES | IF YES, GIVE WAR OR DATES: 20YRS.RET. | 16b SOCIAL SECURITY NO.: 277-22-6921 | 17 INFORMANT: CHRISTINE P. CLARY | ADDRESS: SAME AS #13 |

MEDICAL CERTIFICATION

18 **CAUSE OF DEATH** (Enter only one cause per line for (a), (b) and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Squamous Cell Lung Cancer — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 12 Months

DUE TO, OR AS A CONSEQUENCE OF (b):

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Arteriosclerotic Cardiovascular Disease

| | | | |
|---|---|---|---|
| 19a DATE OF OPERATION | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a AUTOPSY? YES [ ] NO [X] | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ] |
| 21a ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | |

22a I certify that (I) (this hospital) attended the deceased from SEPT 19 86 to OCT 19 19 87 that (I) (we) last saw the deceased alive on OCT 19 19 87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.

22b SIGNATURE: Martin H Cohen, MD — DEGREE: ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ] — 22c DATE SIGNED: 10/29/87

22d PHYSICIAN'S NAME (TYPE OR PRINT): MARTIN H. COHEN — 22e ADDRESS: 50 IRVING ST NW Washington DC 20422

| | | | |
|---|---|---|---|
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL | 23b DATE: 11-2-87 | 23c NAME OF CEMETERY OR CREMATORY: MARYLAND VETS. CEM. | 23d LOCATION CITY OR TOWN: CHELTENHAM COUNTY: P.G. STATE: MARYLAND |
| 24 FUNERAL DIRECTOR NAME AND ADDRESS: AREHART FUNERAL HOME, INC. LA PLATA, MD. | 25a DATE REC'D BY REGISTRAR: NOV 04 1987 | 25b REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been completed by attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. Above corbonpapers. Pages

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH 16 50M 1-81 (VRA 15, 4)

067929 OCT 7 8 87

STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

87 29561

REG. NO

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | | | | | |
|---|---|---|---|---|---|
| 1 DECEASED NAME (TYPE OR PRINT) FIRST: Maggie | MIDDLE: M. | LAST: Margaret Collins | 2a DATE OF DEATH MONTH DAY YEAR: October 4, 1987 | | 2b HOUR: 2:53a M |
| 3 SEX: Female | 4 RACE: White | 5 DATE OF BIRTH MONTH DAY YEAR: 03/15/17 | 6 AGE (IN YEARS LAST BIRTHDAY): 70 YRS. | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 1 DAY HOURS / MIN. |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY): Virginia | 7b CITIZEN OF WHAT COUNTRY?: U.S.A. | 8 MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9 BALTIMORE CITY OR COUNTY OF DEATH: Charles County MD | | |
| 10 CITY OR TOWN OF DEATH: LaPlata, Md. | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Physicians Memorial Hospital | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Home Maker | | 12b KIND OF BUSINESS OR INDUSTRY: at Home |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE: Maryland | 13b COUNTY: Charles | 13c CITY OR TOWN: Nanjemoy | 13d INSIDE CITY LIMITS? YES [ ] NO [X] | 13e STREET ADDRESS / ZIP CODE: Bowie Road , Box 41 E 20662 | |
| 14 FATHER'S NAME FIRST: Scott | MIDDLE | LAST: Collins | 15 MOTHER'S MAIDEN NAME FIRST: Dora | MIDDLE: | LAST: Gibson |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO | (IF YES, GIVE WAR OR DATES) | 16b SOCIAL SECURITY NO.: 213-46-6838 | 17 INFORMANT: Roosevelt Collins-Husband | ADDRESS: Box 41 E Nanjemoy, Md. | |

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Cardiopulmonary Arrest | 6 min |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) | Irreversible severe Heart Failure | 10 mnds. |
| DUE TO, OR AS A CONSEQUENCE OF (c) | Chron Obstructive Lung disease | 5 yrs |

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Anemia, gastric bleeding, erosive gastritis

| | | | |
|---|---|---|---|
| 19a DATE OF OPERATION: N/A | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED: N/A | 20a AUTOPSY? YES [ ] NO [X] | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] N/A NO [ ] |
| 21a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY STATE'S ATTORNEY): N/A | 21b TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19: N/A | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART II): N/A | |
| 21d INJURY OCCURRED HOME [ ] STREET AT WORK [ ]: N/A | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.): N/A | 21f LOCATION STREET: N/A CITY OR TOWN COUNTY STATE | |

22a I certify that (I) (this hospital) attended the deceased from 9/9 1986 to 10/4 1987 that (I) (we) last saw the deceased alive on 10/3 1987 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b SIGNATURE: Paul E. Pritchett MD DEGREE: ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ] — 22c DATE SIGNED: 10/4/87

| | |
|---|---|
| 22d PHYSICIAN'S NAME (TYPE OR PRINT): Paul E. Pritchett, M.D. | 22e ADDRESS: 118 LaGrange Ave. LaPLata, Md. 20646 |

| | | | |
|---|---|---|---|
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY): Burial | 23b DATE: 10/06787 | 23c NAME OF CEMETERY OR CREMATORY: Nazerine Cemetery | 23d LOCATION CITY OR TOWN COUNTY STATE: Pisgah , Charles Co., Md. |

| | | | |
|---|---|---|---|
| 24 FUNERAL DIRECTOR NAME: Arehart Funeral Home, Inc. | ADDRESS: La Plata, Md. | 25a DATE REC'D BY REGISTRAR: OCT 07 1987 | 25b REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

070038 OCT 28 87

FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

87 29568

REG NO

| 1 DECEASED NAME (TYPE OR PRINT) FIRST | MIDDLE | LAST | 2a DATE OF DEATH MONTH DAY YEAR | 2b HOUR |
|---|---|---|---|---|
| Samuel | Alvin | Fink | October 23, 1987 | 5:57P M |

| 3 SEX | 4 RACE | 5 DATE OF BIRTH MONTH DAY YEAR | 6 AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS HOURS MIN |
|---|---|---|---|---|---|
| male | white | July 3, 1918 | 69 YRS | | |

| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b CITIZEN OF WHAT COUNTRY? | 8 | 9 BALTIMORE CITY OR COUNTY OF DEATH |
|---|---|---|---|
| Pennsylvania | U.S.A. | MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | Charles MD |

| 10 CITY OR TOWN OF DEATH | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| La Plata | Physicians Memorial Hospital | Driver | Trucking |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a STATE | 13b COUNTY | 13c CITY OR TOWN | 13d INSIDE CITY LIMITS? | 13e STREET ADDRESS / ZIP CODE |
|---|---|---|---|---|
| Maryland | Charles | LaPlata | YES [X] NO [ ] | #1 Hickory Ln., Apt-512 20646 |

| 14 FATHER'S NAME FIRST | MIDDLE | LAST | 15 MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| William | Thomas | Fink | Blanche | Maybelle | Beckwith |

| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b SOCIAL SECURITY NO | 17 INFORMANT ADDRESS |
|---|---|---|---|
| No | - - - - | 202-01-1635 | Alice G. Fink (Spouse) -Same as #13- |

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)

PART I DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) Cardiac arrest-

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF (b) Myocardial Infarct

DUE TO, OR AS A CONSEQUENCE OF (c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

Emphysema -

| 19a DATE OF OPERATION | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a AUTOPSY? YES [ ] NO [X] | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ] |
|---|---|---|---|
| | | | |

| 21a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |
|---|---|---|
| | | |

| 21d INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f LOCATION STREET CITY OR TOWN COUNTY STATE |
|---|---|---|
| | | |

22a I certify that I (this hospital) attended the deceased from April 19 77 to 10-23- 19 87 that I (we) last saw the deceased alive on 10-23- 19 87, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. I (we) did (did not) view the body after death.

| 22b SIGNATURE | DEGREE | 22c DATE SIGNED |
|---|---|---|
| [signature] | M.D. ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [X] STAFF PHYSICIAN [ ] | 10/24/87 |

| 22d PHYSICIAN'S NAME (TYPE OR PRINT) | 22e ADDRESS |
|---|---|
| Girija S. Rath, M.D. | La Plata, Maryland |

| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b DATE | 23c NAME OF CEMETERY OR CREMATORY | 23d LOCATION CITY OR TOWN COUNTY STATE |
|---|---|---|---|
| Cremation | 10/26/87 | Huntt Crematory | Waldorf, Charles, Maryland |

| 24 FUNERAL DIRECTOR NAME | ADDRESS | 25a DATE REC'D BY REGISTRAR | 25b REGISTRAR'S SIGNATURE |
|---|---|---|---|
| Huntt Funeral Home | P.O. Box 156 Waldorf, Md 20601 | OCT 27 '87 | |

IMPORTANT If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified before release.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be delivered within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

068247 OCT 1987

FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

87 29567

REG. NO.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: Elsie | MIDDLE: Louise | LAST: Evans Ford | 2a. DATE OF DEATH MONTH DAY YEAR: October 2, 1987 | 2b. HOUR: 2:12P M | |
| 3. SEX: Female | 4. RACE: White | 5. DATE OF BIRTH MONTH DAY YEAR: Jan. 27, 1906 | 6. AGE (IN YEARS LAST BIRTHDAY): 81 YRS | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 1 DAY HOURS / MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MD. | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: Charles MD | | |
| 10. CITY OR TOWN OF DEATH: LaPlata | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Physicians Memorial Hospital | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY | | |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| | | | | |
|---|---|---|---|---|
| 13a. STATE: MD. | 13b. COUNTY: St. Mary's | 13c. CITY OR TOWN: Lexington Park | 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ | 13e. STREET ADDRESS / ZIP CODE: 126 Town Creek Manor/20653 |

| | | | |
|---|---|---|---|
| 14. FATHER'S NAME FIRST: Alexandria | MIDDLE: W | LAST: Evans | 15. MOTHER'S MAIDEN NAME FIRST: Susan MIDDLE: LAST: Hardester |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO: 220-12-2463 | 17. INFORMANT ADDRESS: Jean F. Owens, Lexington Park, MD. | 408 Erickson Ct. |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** Enter only one cause per line for (a), (b), and (c). APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cardiac arrest

DUE TO, OR AS A CONSEQUENCE OF (b): Metastatic Breast Cancer.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |

| | | |
|---|---|---|
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |

22a. I certify that (I) (this hospital) attended the deceased from 9/15/87 to 10/2/87 that (I) (we) last saw the deceased alive on 10/2/87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| | | |
|---|---|---|
| 22b. SIGNATURE: N. Seetaramayya | DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 22c. DATE SIGNED: 10/2/87 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT): Seetaramayya Nagula, MD | 22e. ADDRESS: Waldorf, Maryland | |

| | | | |
|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial | 23b. DATE: 10-05-87 | 23c. NAME OF CEMETERY OR CREMATORY: Sunnyridge Memorial Park | 23d. LOCATION CITY OR TOWN / COUNTY / STATE: Crisfield, Somerset, MD. |

| | | |
|---|---|---|
| 24. FUNERAL DIRECTOR NAME / ADDRESS: W. Clarke Mattingley, Leonardtown, MD. | 25a. DATE REC'D. BY REGISTRAR: OCT 8 1987 | 25b. REGISTRAR'S SIGNATURE: Julia Davidson-Landau |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please release cadaver. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified before any action is taken.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

068827 OCT 16 87

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 87 29570

| 1. DECEASED NAME (TYPE OR PRINT) FIRST | MIDDLE | LAST | 2a. DATE OF DEATH MONTH DAY YEAR | 2b. HOUR |
|---|---|---|---|---|
| Mary | A. | Graulich | 10-11-87 | 2:55 am |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 1 DAY HOURS MINS |
|---|---|---|---|---|---|
| Female | Caucasian | April 22 1900 | 87 YRS | | |

| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH |
|---|---|---|---|
| New York | U.S.A. | | Charles MD |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| La Plata | Physicians Memorial Hosp | Housewife | N/A |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS / ZIP CODE |
|---|---|---|---|---|
| Maryland | Prince George | Suitland | YES ☒ NO ☐ | 4706 Medora Dr. 20746 |

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| John | | Koener | Mary | | Sansburg |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | 055-01-3887 | Mary Riordan | 4706 Medora Drive Suitland, Maryland |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH. Enter only one cause per line for a., b., and c.

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Probable cardiac arrest

DUE TO, OR AS A CONSEQUENCE OF (b) Advanced Atherosclerotic Disease

DUE TO, OR AS A CONSEQUENCE OF (c) Hypertension

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART II) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET | CITY OR TOWN | COUNTY | STATE |
|---|---|---|---|---|---|
| | | | | | |

22a. I certify that (I) (this hospital) attended the deceased from 9 27 19 to 10/11 19 87 that (I) (we) last saw the deceased alive on 10/9 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. I (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| George H. Watkins | ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 10/11/87 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| GEORGE H. WATKINS | LA PLATA, MD 20646 |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN | COUNTY | STATE |
|---|---|---|---|---|---|
| Burial | 10/14/87 | Maryland Veterans Cem. | Cheltenham | P.G. | Maryland |

| 24. FUNERAL DIRECTOR NAME | ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| George P. Kalas Funeral Home | 6160 Oxon Hill Rd. Oxon Hill, Md. | OCT 15 1987 | Julia Riordan-Kemper |

IMPORTANT: If item 21 is marked, or there is any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be mailed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

+GR

070155 OCT 29 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1- FOR STATE REGISTRAR

REG. NO. 29571

1. DECEASED NAME (TYPE OR PRINT) FIRST George MIDDLE N/M/N LAST Hack

George Hack

2a. DATE KNOWN OF DEATH / ESTIMATED: X MONTH 10 DAY 24 YEAR 19 87 — 2b. HOUR 06.55 A M

3. SEX: M — 4. RACE: W — 5. DATE OF BIRTH: MONTH 01 DAY 12 YEAR 00 — 6. AGE (IN YEARS LAST BIRTHDAY): 87 YRS — IF UNDER 1 YR: MONTHS, DAYS — IF UNDER 24 HRS: HOURS, MIN

2c. DATE PRONOUNCED DEAD: MONTH 10 DAY 24 YEAR 19 87 — 2d. HOUR 06.55 A M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): New York

7b. CITIZEN OF WHAT COUNTRY? USA

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED X DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Charles County, MD

10. CITY OR TOWN OF DEATH: Port Tobacco

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Chapel Point Road

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Postal Wrkr.-Ret. U.S.Govt.

12b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: MD — 13b. COUNTY: Charles — 13c. CITY OR TOWN: Port Tobacco — 13d. INSIDE CITY LIMITS? YES ☐ NO X — 13e. STREET ADDRESS: Chapel Point Rd

14. FATHER'S NAME: FIRST Jacob MIDDLE LAST Hack

15. MOTHER'S MAIDEN NAME: FIRST Margaret MIDDLE LAST Hack

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): Yes — (IF YES, GIVE WAR OR DATES): W.W.I

16b. SOCIAL SECURITY NO.: 220-44-7887

17. INFORMANT: Madeline M. Joyner, Hughesville, Md. — ADDRESS: P.O.Box 429

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Respiratory Failure

DUE TO, OR AS A CONSEQUENCE OF

(b): COPD

DUE TO, OR AS A CONSEQUENCE OF

(c):

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY? YES ☐ NO X

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection X, Inquiry X, and in my opinion death resulted from: Natural causes X, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE: David N. Gnyrch M.D. — TITLE (SPECIFY): Assistant MEDICAL EXAMINER — DATE SIGNED: 10/24/87

EXAMINER'S NAME (TYPE OR PRINT): DAVID N. GNYRCH — ADDRESS: 5019 Woodhaven Dr. La Plata, MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial — 23b. DATE: 10/26/87 — 23c. NAME OF CEMETERY OR CREMATORY: Trinity Memorial Grdns, Waldorf, Charles, Md. — 23d. LOCATION CITY OR TOWN COUNTY STATE

24. FUNERAL DIRECTOR NAME ADDRESS: Arehart Funeral Home, Inc., La Plata, Md.

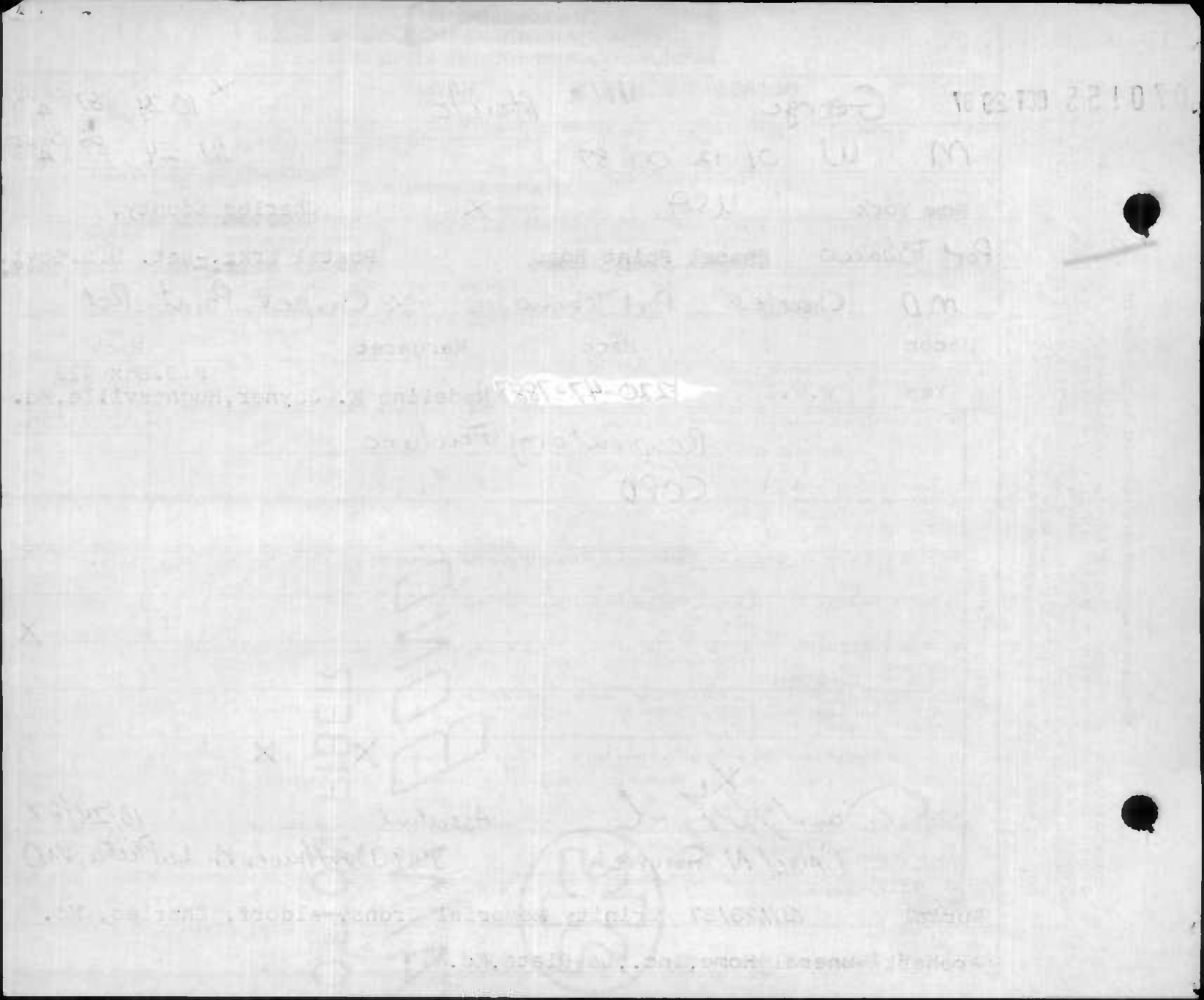
25a. DATE REC'D. BY REGISTRAR: OCT 28 1987 — 25b. REGISTRAR'S SIGNATURE

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM RM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/ B2



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 29572

0706805 NOV -8 87

1. DECEASED NAME (TYPE OR PRINT): MATTHEW WILLIAM HANCOCK
2a. DATE OF DEATH KNOWN / ESTIMATED: x 10 27 1987
2b. HOUR: M
3. SEX: Male
4. RACE: White
5. DATE OF BIRTH: Oct. 29 68
6. AGE (IN YEARS LAST BIRTHDAY): 18 YRS.
IF UNDER 1 YR: MONTHS / DAYS
IF UNDER 24 HRS: HOURS / MIN
7c. DATE PRONOUNCED DEAD: 10 27 1987
7d. HOUR: 8:20 AM
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland
7b. CITIZEN OF WHAT COUNTRY?: U.S.A.
8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
9. BALTIMORE CITY OR COUNTY OF DEATH: Charles County MD
10. CITY OR TOWN OF DEATH: La Plata
11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): (driveway) Box 128 Bel Alton Newtown Rd.
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Programer
12b. KIND OF BUSINESS OR INDUSTRY: Computers

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: Maryland
13b. COUNTY: Charles
13c. CITY OR TOWN: LaPlata
13d. INSIDE CITY LIMITS? YES ☐ NO ☒
13e. STREET ADDRESS: 128 Bel Alton Newton Road 20646

14. FATHER'S NAME: Harold Lee Hancock
15. MOTHER'S MAIDEN NAME: Norma Ann McDonagh
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): No
(IF YES, GIVE WAR OR DATES)
16b. SOCIAL SECURITY NO.: 217-98-3495
17. INFORMANT: Norma McD. Hancock
ADDRESS: 128 Bel Alton Newton Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Gunshot wound of head (handgun)
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b):
DUE TO, OR AS A CONSEQUENCE OF (c):
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION:
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?:
20. AUTOPSY? YES ☒ Head Only NO ☐

21a. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH
21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR: 10-27-1987
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2): Self-inflicted.
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.): driveway
21f. LOCATION STREET: Box 128 Bel Alton Newtown Rd. CITY OR TOWN: La Plata, COUNTY: Charles STATE: MD

22a. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: [signature] M.D.
TITLE (SPECIFY): Assistant MEDICAL EXAMINER
DATE SIGNED: 10-27-87
EXAMINER'S NAME (TYPE OR PRINT): Charles P. Kokes, M.D.
ADDRESS: 111 Penn St., Balto., MD 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
23b. DATE: 10/30/87
23c. NAME OF CEMETERY OR CREMATORY: United Methodist
23d. LOCATION CITY OR TOWN: Dentsville COUNTY: Charles STATE: Md.

24. FUNERAL DIRECTOR NAME / ADDRESS: Arehart Funeral Home, Inc. LaPlata, Md.
25a. DATE REC'D. BY REGISTRAR: NOV 2 1987
25b. REGISTRAR'S SIGNATURE: Julia Davidson-Landers

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84 25M BP
DHMH - 17
(VR A15 ME (5))

071067 NOV 6 87

FOR 1 - STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 87 29573

| 1. DECEASED NAME (TYPE OR PRINT) FIRST | MIDDLE | LAST | 2a. DATE OF DEATH MONTH | DAY | YEAR | 2b. HOUR |
|---|---|---|---|---|---|---|
| Lorenzo | Seymour | Hawkins | 10 | 26 | 87 | 9:35 AM |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH | DAY | YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR MONTHS | DAYS | IF UNDER 24 HRS. HOURS | MIN. |
|---|---|---|---|---|---|---|---|---|---|
| Male | Black | 4 | 24 | 1899 | 88 YRS. | | | | |

| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH |
|---|---|---|---|
| Newport, Md. | U.S.A. | | Charles County, MD |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| La Plata | Meridian Nursing Center | Farmer | Farming |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS / ZIP CODE |
|---|---|---|---|---|
| Maryland | Charles | Faulkner | YES ☐ NO ☒ | General Delivery 20632 |

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| William | Lorenzo | Hawkins | Mary | | Green |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | 217-30-2358 | Eleanor Chase | P.O. Box 174 Faulkner, Md. |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Pneumonia — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 week

DUE TO, OR AS A CONSEQUENCE OF (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: Congestive heart failure

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET | CITY OR TOWN | COUNTY | STATE |
|---|---|---|---|---|---|
| | | | | | |

22a. I certify that (I) (this hospital) attended the deceased from 9-27 19 87 to 10-26 19 87 that (I) (we) last saw the deceased alive on 10-26 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 22c. DATE SIGNED |
|---|---|---|
| [signature] | | 10-27-87 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| Daniel M. Howell, M.D. | Charles Street, La Plata, Md. 20646 |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN | COUNTY | STATE |
|---|---|---|---|---|---|
| Burial | 10/30/87 | St. Ignatius | Chapel Point | Charles | Md. |

| 24. FUNERAL DIRECTOR NAME | ADDRESS | 25a. DATE REC'D BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| Arehart Funeral Home, Inc., | La Plata, Md. | NOV 02 1987 | [signature] |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use in the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked, or if the circumstances of death suggest injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP_____

DHMH - 16 60M 7/84
(VRA 15. 4)

070339 OCT 30 '87

FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO 2951

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified before disposition.

BP_____

DHMH - 16 60M 7/84 (VRA 15, 4)

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) First: Mary Middle: Anna Last: Hedrick — Mary Anna Hedrick | | | | 2a. DATE OF DEATH Month/Day/Year: October 25, 87 | 2b. HOUR: 10 PM |
| 3. SEX: Female | 4. RACE: WHITE | 5. DATE OF BIRTH Month/Day/Year: 09/05/98 | 6. AGE (IN YEARS LAST BIRTHDAY): 89 YRS | IF UNDER 1 YEAR: Months / Days | IF UNDER 24 HRS.: Hours / Min. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MD. | 7b. CITIZEN OF WHAT COUNTRY?: U.S | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: CHARLES MD | | |
| 10. CITY OR TOWN OF DEATH: LA PLATA | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Charles County Nursing Home | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Civil Service | 12b. KIND OF BUSINESS OR INDUSTRY: Govt | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MD | 13b. COUNTY: CH. | 13c. CITY OR TOWN: Waldorf | 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ | 13e. STREET ADDRESS / ZIP CODE: 11096 Heritage Place 20601 | |
| 14. FATHER'S NAME First: John Middle: Grant Last: Jameson | | | 15. MOTHER'S MAIDEN NAME First: Martha Middle: Elizabeth Last: Boarman | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): yes | 16b. (IF YES, GIVE WAR OR DATES): WW I | SOCIAL SECURITY NO.: 579-58-1269 | 17. INFORMANT: Linda Woodard Gaither | ADDRESS: 13843 Grey Colt Drive Germantown, MD. 20878 | |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b) and (c).)

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) RESPIRATORY ARREST — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DUE TO, OR AS A CONSEQUENCE OF (b) CONGESTIVE HEART FAILURE

DUE TO, OR AS A CONSEQUENCE OF (c) ATHEROSCLEROTIC HEART DISEASE

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). Chronic Renal Failure, Anemia, Polyarthritis

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☒ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |

| | | | |
|---|---|---|---|
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH ☐ (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART II) | |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION: STREET / CITY OR TOWN / COUNTY / STATE | |

22a. I certify that (I) (this hospital) attended the deceased from 9/3/87, 19____, to 10/25/87, 19____, that (I) (last) saw the deceased alive on 10/5/87, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ 22c. DATE SIGNED: 10/26/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Dr. Sanjeeb K. Mishra

22e. ADDRESS: Waldorf, Md. 20601

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL: Burial | 23b. DATE: 10-28-87 | 23c. NAME OF CEMETERY OR CREMATORY: St. Mary's Ch. Cem | 23d. LOCATION: CITY OR TOWN: Bryantown / COUNTY: Chas. / STATE: Md. | |
| 24. FUNERAL DIRECTOR: Hunt Funeral Home | ADDRESS: P. O. Box 156 Waldorf, Md. 20601 | 25a. DATE REC'D. BY REGISTRAR: OCT 28 1987 | 25b. REGISTRAR'S SIGNATURE: [signature] | |

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

170730 NOV -4 87 FOR STATE REGISTRAR

REG. NO. 29575

1. DECEASED NAME (TYPE OR PRINT) — FIRST: Kevin; MIDDLE: Marshall; LAST: Heflin

2a. DATE KNOWN OF DEATH [X] ESTIMATED [ ] — MONTH DAY YEAR: 10-31 19 87

2b. HOUR: M

3. SEX: Male

4. RACE: Cau.

5. DATE OF BIRTH — MONTH DAY YEAR: Sept. 9, 1970

6. AGE (IN YEARS LAST BIRTHDAY): 17 YRS.

IF UNDER 1 YR. — MONTHS / DAYS

IF UNDER 24 HRS. — HOURS / MIN.

2c. DATE PRONOUNCED DEAD — MONTH DAY YEAR: 10-31 19 87

2d. HOUR: 4:20 M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): D.C.

7b. CITIZEN OF WHAT COUNTRY?: U.S.A.

8. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]

9. BALTIMORE CITY OR COUNTY OF DEATH: Charles County MD

10. CITY OR TOWN OF DEATH: La Plata

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Physicians Memorial Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Student

12b. KIND OF BUSINESS OR INDUSTRY: College

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Md.

13b. COUNTY: Charles

13c. CITY OR TOWN: Waldorf

13d. INSIDE CITY LIMITS? YES [X] NO [ ]

13e. STREET ADDRESS: 11 Lancelot Drive 20601

14. FATHER'S NAME — FIRST MIDDLE LAST: Charles Marshall Heflin III

15. MOTHER'S MAIDEN NAME — FIRST MIDDLE LAST: Nancy Diane Barnes

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): No

(IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 579-86-6317

17. INFORMANT — ADDRESS: 11 Lancelot Drive; Kenneth R. Watson, Waldorf, Md 20601

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Head and chest injuries

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b):

DUE TO, OR AS A CONSEQUENCE OF (c):

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

19a. DATE OF OPERATION:

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?:

20. AUTOPSY? YES [X] NO [ ]

21a. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH

21b. TIME OF INJURY — HOUR A.M. P.M. MONTH DAY YEAR: 3:00 A.M. 10-31-87

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2): Driver in auto/auto collision

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.): road

21f. LOCATION — STREET CITY OR TOWN COUNTY STATE: Route 228, Waldorf, Charles County, MD

22a. I certify that I took charge of the remains described above, held an Autopsy [X] Inspection [ ] Inquiry [ ] and in my opinion death resulted from: Natural causes [ ] Accident [X] Suicide [ ] Homicide [ ] Undetermined manner [ ].

ACTUAL SIGNATURE: [signature] M.D.

TITLE (SPECIFY): Deputy chief MEDICAL EXAMINER

DATE SIGNED: 10-31-87

EXAMINER'S NAME (TYPE OR PRINT): Ann M. Dixon, M.D.

ADDRESS: 111 Penn Street, Baltimore, MD 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 11-3-87

23c. NAME OF CEMETERY OR CREMATORY: Mt. Comfort Cem.

23d. LOCATION — CITY OR TOWN COUNTY STATE: Alexindria, Virginia

24. FUNERAL DIRECTOR — NAME ADDRESS: Huntt Funeral Home Inc., Waldorf, Md.

25a. DATE REC'D. BY REGISTRAR: NOV 03 1987

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Landeck

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2 AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM, PM 3. PAGE 5 FOR YOUR FILES.
**TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07-84 25M BP

DHMH - 17 (VR A15 ME (5))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO 29576

070159 OCT 29 87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use in the burial/removal permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of case.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: Eleanor | MIDDLE: Swann | LAST: Kersey | 2a. DATE OF DEATH MONTH DAY YEAR: October 26, 1987 | 2b. HOUR: 7:32PM | |
| 3. SEX: Female | 4. RACE: Caucasian | 5. DATE OF BIRTH MONTH DAY YEAR: April 29, 1924 | 6. AGE (IN YEARS LAST BIRTHDAY): 63 YRS. | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS. HOURS / MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland | 7b. CITIZEN OF WHAT COUNTRY?: United States | 8. MARRIED X / NEVER MARRIED / WIDOWED / DIVORCED | 9. BALTIMORE CITY OR COUNTY OF DEATH: Charles MD | | |
| 10. CITY OR TOWN OF DEATH: Waldorf | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Box 125, Terrace Drive | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Housewife | 12b. KIND OF BUSINESS OR INDUSTRY: Home | | |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS / ZIP CODE |
|---|---|---|---|---|
| MD | Charles | Waldorf | YES / NO X | Box 125, Terrace Drive 20601 |

| 14. FATHER'S NAME (FIRST MIDDLE LAST) | 15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) |
|---|---|
| Percy H. Swann | Mary Rebecca Welch |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT (NAME AND ADDRESS) |
|---|---|---|---|
| NO | | 220-16-7776 | James T. Kersey, Sr. Box 125, Terrace Drive Waldorf MD 20601 |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardio Respiratory Arrest

DUE TO, OR AS A CONSEQUENCE OF (b) Emphysema

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Cerebrovascular Disease

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES / NO X | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES / NO |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |
|---|---|---|
| 21d. INJURY OCCURRED WHILE AT WORK / NOT WHILE AT WORK | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE |

22a. I certify that (I) (~~this hospital~~) attended the deceased from April 19 81, to 10-26- 19 87, that (I) (we) last saw the deceased alive on 10-2- 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (~~we~~) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| G S Rath | M D ATTENDING PHYSICIAN / MEDICAL DIRECTOR X / STAFF PHYSICIAN | 10-27-87 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| G.S.RATH | CHARLES PROFESSIONAL BLDG, WALDORF, MD. 20601 |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| Burial | 10/29/72 | St. Peters Ch. Cem | Waldorf Chas. Md. |

| 24. FUNERAL DIRECTOR NAME | ADDRESS | | | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|---|---|
| The Huntt Funeral Home, Inc. | P.O. Box 156 | Waldorf | MD 20601-0156 | OCT 28 1987 | |

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

069634 OCT 26 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR STATE REGISTRAR

REG. NO 87 29511

1. DECEASED NAME (TYPE OR PRINT): Marjorie G. Laymon
2a. DATE OF DEATH: 10/18/87
2b. HOUR: 6:02 PM
3. SEX: Female
4. RACE: White
5. DATE OF BIRTH: August 31, 1925
6. AGE (IN YEARS LAST BIRTHDAY): 62
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Pennsylvania
7b. CITIZEN OF WHAT COUNTRY?: USA
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED XX
9. BALTIMORE CITY OR COUNTY OF DEATH: Charles MD
10. CITY OR TOWN OF DEATH: La Plata
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Physicians Memorial Hospital
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Secretary
12b. KIND OF BUSINESS OR INDUSTRY: AFL-CIO Union

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: Maryland
13b. COUNTY: Charles
13c. CITY OR TOWN: La Plata
13d. INSIDE CITY LIMITS? YES ☐ NO ☐
13e. STREET ADDRESS / ZIP CODE: P.O. Box 1022 20646

14. FATHER'S NAME: Robert Gray
15. MOTHER'S MAIDEN NAME: Margaret Smitley
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No (IF YES, GIVE WAR OR DATES)
16b. SOCIAL SECURITY NO.: 202-14-6695
17. INFORMANT: Susan Detwiler ADDRESS: P.O. Box 0 La Plata Md 20646

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Cardiopulmonary arrest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 6 min
DUE TO, OR AS A CONSEQUENCE OF (b): Hepatic failure — 5 day
DUE TO, OR AS A CONSEQUENCE OF (c): Hepatocellular disease - nonalcoholic type — 7 yrs
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: septicemia - Staph a. coag pos, Diabetes, Coronary artery disease, Pacemaker

19a. DATE OF OPERATION: n/a
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: N/A
20a. AUTOPSY? YES ☐ NO X
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ N/A NO ☐
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH ☐ N/A (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY HOUR A.M. P.M. MONTH N/A DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2): N/A
21d. INJURY OCCURRED WHILE AT WORK ☐ N/A
21e. PLACE OF INJURY (AT HOME, STREET, FARM, OFFICE BLDG., ETC.): N/A
21f. LOCATION STREET: N/A CITY OR TOWN COUNTY STATE

22a. I certify that I (this hospital) attended the deceased from 10/5 19 87 to 10/18 19 87 that I (we) last saw the deceased alive on 10/17 19 87 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. I (we) did (did not) view the body after death.
22b. SIGNATURE: Paul Pritchett (MD) DEGREE: ATTENDING PHYSICIAN X MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐
22c. DATE SIGNED: 10/19/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT): DR. PAUL PRITCHETT
22e. ADDRESS: LA GRANGE AVE - LA PLATA MD 20646

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
23b. DATE: 22Aug1987
23c. NAME OF CEMETERY OR CREMATORY: Mount Auburn Cem
23d. LOCATION CITY OR TOWN: Dunbar COUNTY: Fayette STATE: Pa
24. FUNERAL DIRECTOR NAME: Robert E Wilhelm Funeral Home ADDRESS: Suitland, Md.
25. DATE REC'D BY REGISTRAR: OCT 23 1987
25b. REGISTRAR'S SIGNATURE: [signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please forward pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7-84
(VRA 15, 4)

070382 NOV-2 87

FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG NO 29318

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | | | | |
|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: Edith; MIDDLE: ANNETHY; LAST: Lundholm | | | 2a. DATE OF DEATH MONTH DAY YEAR: October 28, 1987 | 2b. HOUR: 7:15 PM |
| 3. SEX: Female | 4. RACE: Caucasian | 5. DATE OF BIRTH MONTH DAY YEAR: April 12, 1902 | 6. AGE (IN YEARS LAST BIRTHDAY): 85 YRS | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 1 DAY: HOURS / MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Sweden | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED XX DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: Charles MD | |
| 10. CITY OR TOWN OF DEATH: La Plata | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Physicians Memorial Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Home maker | 12b. KIND OF BUSINESS OR INDUSTRY: Own Home |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland | 13b. COUNTY: Charles | 13c. CITY OR TOWN: LaPlata | 13d. INSIDE CITY LIMITS? YES XX NO ☐ | 13e. STREET ADDRESS / ZIP CODE: Rt-2 Box-2364S / 20646 |
| 14. FATHER'S NAME FIRST MIDDLE LAST: UNAVAILABLE | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST: UNAVAILABLE | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): None | (IF YES, GIVE WAR OR DATES): - - - - | 16b. SOCIAL SECURITY NO.: 218-38-9378 | 17. INFORMANT: Frank R. Lundholm | ADDRESS: 8012 Darcy Rd. Forestville, Md 20747 |

**MEDICAL CERTIFICATION**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Cardiorespiratory Arrest
DUE TO, OR AS A CONSEQUENCE OF (b): Pneumonia
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO, OR AS A CONSEQUENCE OF (c):
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO X | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) ☐ | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEMS 18 PART I OR PART 2) | |
| 21d. INJURY OCCURRED (HOME ☐ AT WORK ☐ NOT WHILE AT WORK ☐) | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION (STREET, CITY OR TOWN, COUNTY, STATE) | |

22a. I certify that I (this hospital) attended the deceased from 23 OCT 1987 to 28 OCT 1987 that I (we) last saw the deceased alive on 28 OCT 87 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. I (we) (did not) view the body after death.

| | | |
|---|---|---|
| 22b. SIGNATURE: A Stephen Hansman | DEGREE: ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☑ | 22c. DATE SIGNED: 10/29/87 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT): A Stephen Hansman MD<br>George Wathen M.D | 22e. ADDRESS: Waldorf, Md | |

| | | | |
|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial | 23b. DATE: 10/31/87 | 23c. NAME OF CEMETERY OR CREMATORY: Resurrection Cem | 23d. LOCATION (CITY OR TOWN, COUNTY, STATE): Clinton, Pr.Geo., Md. |
| 24. FUNERAL DIRECTOR (NAME): Huntt Funeral Home | P.O.Box 156 Waldorf, Md 20601 | 25a. DATE REC'D BY REGISTRAR: OCT 30 1987 | 25b. REGISTRAR'S SIGNATURE: Julia Tenison-Landers |

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

0693999 OCT 23 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REGISTRAR'S DATE
REG. NO. 29577

1. DECEASED NAME (TYPE OR PRINT): JOHN (FIRST) Edward (MIDDLE) McCLELLAND (LAST)

2a. DATE OF DEATH: KNOWN X ESTIMATED ☐ MONTH 10 DAY 10 YEAR 1987 — 2b. HOUR M

3. SEX: Male — 4. RACE: White — 5. DATE OF BIRTH: MONTH 02 DAY 04 YEAR 1912 — 6. AGE (IN YEARS LAST BIRTHDAY): 75 YRS. — IF UNDER 1 YR. MONTHS DAYS — IF UNDER 24 HRS. HOURS MIN

2c. DATE PRONOUNCED DEAD: MONTH 10 DAY 10 YEAR 87 — 2d. HOUR 11A M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Pennsylvania — 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. — 8. MARRIED ☐ NEVER MARRIED X WIDOWED ☐ DIVORCED ☐ — 9. BALTIMORE CITY OR COUNTY OF DEATH: Charles County MD

10. CITY OR TOWN OF DEATH: La Plata — 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Physicians Memorial Hospital — 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Greens Keeper Retired — 12b. KIND OF BUSINESS/INDUSTRY: Country Club

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: Florida — 13b. COUNTY: Seminol — 13c. CITY OR TOWN: Longwood — 13d. INSIDE CITY LIMITS? YES XX NO ☐ — 13e. STREET ADDRESS: 1083 Hunt Road

14. FATHER'S NAME (FIRST MIDDLE LAST): John Adam McClelland — 15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST): Mary Ellen Walsh

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): No — (IF YES, GIVE WAR OR DATES) — 16b. SOCIAL SECURITY NO.: 171-16-9469 — 17. INFORMANT: Harry Baker — ADDRESS: P.O. Box 207 Faulkner, Md. 20632

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hypertensive arteriosclerotic cardiovascular disease
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b):
DUE TO, OR AS A CONSEQUENCE OF (c):
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a.

19a. DATE OF OPERATION — 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? — 20. AUTOPSY? YES X NO ☐

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH — 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 — 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ — 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) — 21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held an Autopsy X. Inspection ☐. Inquiry ☐ and in my opinion death resulted from Natural causes X. Accident ☐. Suicide ☐. Homicide ☐. Undetermined manner ☐.

ACTUAL SIGNATURE: Mario F. Golle Jr. M.D. — TITLE (SPECIFY): Assistant MEDICAL EXAMINER — DATE SIGNED: 10-11-87

EXAMINER'S NAME (TYPE OR PRINT): Mario F. Golle, Jr., M.D. — ADDRESS: 111 Penn St., Balto., MD 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Cremation — 23b. DATE: 10/14/87 — 23c. NAME OF CEMETERY OR CREMATORY: Lee Crematory — 23d. LOCATION CITY OR TOWN: Clinton, COUNTY: Prince Geo., STATE: Md.

24. FUNERAL DIRECTOR NAME: Arehart Funeral Home, Inc. — ADDRESS: La Plata, Md. — 25a. DATE REC'D BY REGISTRAR: OCT 16 1987 — 25b. REGISTRAR'S SIGNATURE: Gordon Randall

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ENCLOSURE IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07 84 25M BP

DHMH 17 (VR A15 ME (5))

071406 NOV 10 87

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

STATE REGISTRAR

REG. NO 87 29580

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: James | MIDDLE: Patrick | LAST: Myles | 2a. DATE OF DEATH MONTH DAY YEAR: October 23, 1987 | 2b. HOUR: 5:54P M | |
| 3. SEX: male | 4. RACE: white | 5. DATE OF BIRTH MONTH DAY YEAR: December 21, 1894 | 6. AGE (IN YEARS LAST BIRTHDAY): 92 YRS. | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Ireland | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: Charles MD | | |
| 10. CITY OR TOWN OF DEATH: La Plata | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Physicians Memorial Hospital | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Window Cleaning/Self -Emply | 12b. KIND OF BUSINESS OR INDUSTRY | | |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS / ZIP CODE |
|---|---|---|---|---|
| Maryland | Charles | Indian Head | YES ☐ NO ☒ | 13 Greenwood Place 20640 |

| 14. FATHER'S NAME FIRST MIDDLE LAST | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | |
|---|---|---|
| Terrence Myles | Mary Meegan | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No | (IF YES, GIVE WAR OR DATES): N/A | 16b. SOCIAL SECURITY NO: 578-46-6581 |
| 17. INFORMANT: John Myles, | ADDRESS: Rt.2 Box 163 Indian Head, Md. 20640 | |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Acute Respiratory Failure

DUE TO, OR AS CONSEQUENCE OF (b): Pulmonary Edema,

DUE TO, OR AS A CONSEQUENCE OF (c):

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Laceration of Scalp & Cerebral Concussion

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| 10/10/87 | Laceration of Scalp | YES ☐ NO ☑ | YES ☐ NO ☐ |

| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 19 OR PART II OR PART III) | |
|---|---|---|---|
| ☑ | 10 10 1987 | Motor Vehicle Accident | |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☑ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET | CITY OR TOWN COUNTY STATE |
| | Street | Rt. 210 | Bryans Rd. Charles Md. |

22a. I certify that (I) (this hospital) attended the deceased from Oct 10, 1987 to Oct 23, 1987 that (I) (we) last saw the deceased alive on Oct 23, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| Arturo M. Monteiro | MD ATTENDING PHYSICIAN ☑ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 10/24/87 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT): Arturo Monteiro, M.D. | 22e. ADDRESS: La Plata, Maryland | |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN COUNTY STATE |
|---|---|---|---|
| Burial | 10/27/87 | St. Charles | Glymont Charles Md. |

| 24. FUNERAL DIRECTOR NAME ADDRESS | 25. DATE REC'D BY REGISTRAR (REGISTRAR) |
|---|---|
| Arehart Funeral Home, Inc., La Plata, Md. | NOV 09 1987 |

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached to use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal from the state.

IMPORTANT If Item 21 is marked "Yes," the injury or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

070043 OCT 28 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE REGISTRAR

REG NO. 29581

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1 AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM ME 5. RETAIN PAGE 5 FOR YOUR FILES.
**TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL

1 DECEASED NAME (TYPE OR PRINT): FIRST Bill MIDDLE N/M/N LAST Napier Sr.

2a DATE OF DEATH: KNOWN X ESTIMATED ☐ MONTH 10 DAY 25 YEAR 19 87 — 2b HOUR 01:57 A M

3 SEX: M — 4 RACE: W — 5 DATE OF BIRTH: MONTH 5 DAY 15 YEAR 26 — 6 AGE (IN YEARS LAST BIRTHDAY): 61 YRS. — IF UNDER 1 YR: MONTHS / DAYS — IF UNDER 24 HRS: HOURS / MIN

2c DATE PRONOUNCED DEAD: MONTH 10 DAY 25 YEAR 19 87 — 2d HOUR 01:57 A M

7a BIRTHPLACE (STATE OR FOREIGN COUNTRY): Kentucky

7b CITIZEN OF WHAT COUNTRY? USA

8 MARITAL STATUS: MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED X

9 BALTIMORE CITY OR COUNTY OF DEATH: Charles MD

10 CITY OR TOWN OF DEATH: La Plata

11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Physicians Memorial Hosp

12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Retired military

12b KIND OF BUSINESS OR INDUSTRY: Service

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a STATE: MD — 13b COUNTY: Charles — 13c CITY OR TOWN: Waldorf — 13d INSIDE CITY LIMITS? YES ☐ NO ☐ — 13e STREET ADDRESS: Rt4 Bx 378 Midway Mob Hom. 20601

14 FATHER'S NAME: FIRST Orpha MIDDLE LAST Napier

15 MOTHER'S MAIDEN NAME: FIRST Martha MIDDLE LAST Campbell

16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): yes — (IF YES, GIVE WAR OR DATES): WWII

16b SOCIAL SECURITY NO.: 403-30-7933

17 INFORMANT: Bill Napier, Jr. — ADDRESS: 4602 Golden Eye Pl Waldorf, Md. 20601

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a): Cardio pulmonary Arrest

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF (b): Coronary Artery Disease

DUE TO, OR AS A CONSEQUENCE OF (c):

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a DATE OF OPERATION

19b CONDITION FOR WHICH OPERATION WAS PERFORMED?

20 AUTOPSY? YES ☐ NO X

21a EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f LOCATION STREET CITY OR TOWN COUNTY STATE

22a I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection X Inquiry X and in my opinion death resulted from Natural causes X Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: David N. Gingrich M.D. — TITLE (SPECIFY): Assistant MEDICAL EXAMINER — DATE SIGNED: 10/25/87

EXAMINER'S NAME (TYPE OR PRINT): DAVID N. Gingrich — ADDRESS: 5019 Woodthrush Dr. LaPlata, MD

23a BURIAL, CREMATION, REMOVAL (SPECIFY): Burial — 23b DATE: 10-28-87 — 23c NAME OF CEMETERY OR CREMATORY: Md. Veterans Cem. — 23d LOCATION (CITY OR TOWN, COUNTY, STATE): Cheltenham Pr. Geo Md.

24 FUNERAL DIRECTOR: Huntt Funeral Home — ADDRESS: P. O. Box 156 Waldorf, Md. 20601

25a DATE REC'D BY REGISTRAR: OCT 27 1987 — 25b REGISTRAR'S SIGNATURE:

BP

DHMH 17 (VR A15 ME (5)) 20M 4-82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

068832 OCT. 16 87

1 - FOR STATE REGISTRAR

REG. NO 87 29582

12:59AM

CARROLL WILLIAM POSEY

1 DECEASED NAME (TYPE OR PRINT) FIRST CARROLL MIDDLE WILLIAM LAST POSEY

2a DATE OF DEATH MONTH 10 DAY 12 YEAR 87

2b HOUR 0059AM

3 SEX MALE

4 RACE Caucasian

5 DATE OF BIRTH MONTH 8 DAY 29 YEAR 28

6 AGE (IN YEARS LAST BIRTHDAY) 59 YRS

IF UNDER 1 YEAR MONTHS DAYS

IF UNDER 24 HRS. HOURS MIN.

7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia

7b CITIZEN OF WHAT COUNTRY? USA

8 MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

9 BALTIMORE CITY OR COUNTY OF DEATH Charles MD.

10 CITY OR TOWN OF DEATH La Plata

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Physicians Memorial Hosp.

12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Electrician

12b KIND OF BUSINESS OR INDUSTRY Electric

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a STATE Maryland

13b COUNTY Charles

13c CITY OR TOWN White Plains

13d INSIDE CITY LIMITS? YES [ ] NO [X]

13e STREET ADDRESS / ZIP CODE Rt. 1, Box 3/20695

14. FATHER'S NAME FIRST Earl MIDDLE S. LAST Posey

15. MOTHER'S MAIDEN NAME FIRST Ada MIDDLE M. LAST Kidwell

16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no

(IF YES, GIVE WAR OR DATES) ---

16b SOCIAL SECURITY NO 217-30-0223

17 INFORMANT Betty Scott

ADDRESS Box 118 Terrace Drive Waldorf, Md. 20601

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for a, b, and c.)

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) CARDIO RESPIRATORY ARREST

DUE TO, OR AS A CONSEQUENCE OF (b) ISCHAEMIC DILATED CARDIOMYOPATHY

DUE TO, OR AS A CONSEQUENCE OF (c) CARCINOMA OF BLADDER

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.

19a DATE OF OPERATION —

19b CONDITION FOR WHICH OPERATION WAS PERFORMED —

20a AUTOPSY? YES [ ] NO [X]

20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART II)

21d INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f LOCATION STREET CITY OR TOWN COUNTY STATE

22a I certify that (I/this hospital) attended the deceased from Feb 87 19 to Oct 87 19 that (I last saw) this deceased alive on 19, and that in (my) (the) opinion death occurred on the date and hour and from the causes stated above. (I/this hospital did not) view the body after death.

23 SIGNATURE Sunisha for DR G.S. RATH DEGREE ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]

22c DATE SIGNED 10/12/87

22d PHYSICIAN'S NAME (TYPE OR PRINT) S.K. MISHRA for DR G.S. RATH

22e ADDRESS Charles Prof. Center, Waldorf, Md

23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial

23b DATE 10-15-87

23c NAME OF CEMETERY OR CREMATORY Oakland Cemetery

23d LOCATION CITY OR TOWN Waldorf COUNTY Chas. STATE Maryland

24 FUNERAL DIRECTOR NAME Huntt Funeral Home ADDRESS P. O. Box 156 Waldorf, Md. 20601

25a DATE RECD. BY REGISTRAR 25b REGISTRAR'S SIGNATURE OCT 15 1987 John Davidson-Kendall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with in 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84 (VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG NO 87 29 83

067921 OCT 87

1. DECEASED NAME (First, Middle, Last): Annie Elizabeth Prince
2a. DATE OF DEATH (Month, Day, Year): October 1,1987
2b. HOUR: 9:25 PM
3. SEX: Female
4. RACE: White
5. DATE OF BIRTH (Month, Day, Year): June 12, 1903
6. AGE (In Years Last Birthday): 84 YRS
7a. BIRTHPLACE (State or Foreign Country): Virginia
7b. CITIZEN OF WHAT COUNTRY?: U.S.A.
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
9. BALTIMORE CITY OR COUNTY OF DEATH: Charles MD
10. CITY OR TOWN OF DEATH: La Plata
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (If not in such facility, give street address): Physicians Memorial Hospital
12a. USUAL OCCUPATION (Type of work for most of working life): Housewife
12b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (If nursing home or other institution, give residence before admission)
13a. STATE: Md.
13b. COUNTY: Charles
13c. CITY OR TOWN: Waldorf
13d. INSIDE CITY LIMITS? YES ☒ NO ☐
13e. STREET ADDRESS / ZIP CODE: 800 Holly Tree Lane 20601

14. FATHER'S NAME: First Preston Middle B. Last Rankin
15. MOTHER'S MAIDEN NAME: First Lozella Middle — Last Stone
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or Unknown): No (If yes, give war or dates)
16b. SOCIAL SECURITY NO: 579-24-5946
17. INFORMANT: Elizabeth J. Bonta
ADDRESS: 800 Holly Tree Lane Waldorf, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH. Enter only one cause per line for (a), (b) and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Respiratory Arrest — Approximate interval between onset and death: —
DUE TO, OR AS A CONSEQUENCE OF (b): Pneumonia — 3 weeks
DUE TO, OR AS A CONSEQUENCE OF (c): Chronic aspiration — months
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: Cerebral vascular accident

19a. DATE OF OPERATION:
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20a. AUTOPSY? YES ☐ NO ☒
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)
21b. TIME OF INJURY: Hour A.M. P.M. Month Day Year 19
21c. HOW INJURY OCCURRED (Enter nature of injury in item 18, Part I or Part II)
21d. INJURY OCCURRED: While at work ☐ Not while at work ☐
21e. PLACE OF INJURY (At home, street, factory, office, farm, etc.)
21f. LOCATION: Street City or Town County State

22a. I certify that (I) this hospital attended the deceased from Aug 21 19 87 to Oct 1 19 87 that (I) (we) last saw the deceased alive on Sept 29 19 87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] MD
DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐
22c. DATE SIGNED: 10/1/87
22d. PHYSICIAN'S NAME (Type or Print): B. Larry Jenkins M.D
22e. ADDRESS: Waldrof, Md 20601

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 10/5/87
23c. NAME OF CEMETERY OR CREMATORY: National Memorial Park
23d. LOCATION: City or Town Falls Church County Fairfax State Va.
24. FUNERAL DIRECTOR: Name Bristow-Faulkner Anthony E. Brooks Address Salida, VA. 23149
25a. DATE REC'D BY REGISTRAR: OCT 07 1987
25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

IMPORTANT: If Item 21 is marked on this certificate, the medical examiner must be notified before any disposition of the body.
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial transit permit. Then please remove carbon paper. Page 1 of this certificate should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal from the state. Page 2 may be removed by the funeral director.
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

0701577 OCT 29 87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

1 - FOR STATE REGISTRAR

**STATE OF MARYLAND**
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**
**CERTIFICATE OF DEATH**

REG. NO 2958

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) | FIRST: David | MIDDLE: John | LAST: Reese Sr. | 2a. DATE OF DEATH MONTH DAY YEAR: 10-26-87 | 2b. HOUR: 2:22 AM | |
| 3. SEX: Male | 4. RACE: Caucasian | 5. DATE OF BIRTH MONTH DAY YEAR: 10-5-1937 | 6. AGE (IN YEARS LAST BIRTHDAY): 50 YRS. | IF UNDER 1 YEAR: DAYS | IF UNDER 1 DAY: HOURS | MIN |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. BALTIMORE CITY OR COUNTY OF DEATH: Charles MD | | | |
| 10. CITY OR TOWN OF DEATH: La Plata | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Physicians Memorial Hospital | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Data Process. | 12b. KIND OF BUSINESS OR INDUSTRY: US Gov't | | | |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS / ZIP CODE |
|---|---|---|---|---|
| Maryland | Charles | Bryans Road | YES [ ] NO [X] | P. O. Box 807/20616 |

| 14. FATHER'S NAME | 15. MOTHER'S MAIDEN NAME |
|---|---|
| FIRST: John MIDDLE: LAST: Reese Sr. | FIRST: Anna MIDDLE: LAST: Sprague |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| no | --- | 218-32-1193 | Margaret Reese | same as #13 |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) malignant melanoma with chest wall metastasis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 11 mos

DUE TO, OR AS A CONSEQUENCE OF (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES [ ] NO [X] | YES [ ] NO [ ] |

| 21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |
|---|---|---|
| 21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE |

22a. I certify that (I) (this hospital) attended the deceased from Sept 21, 19 87 to Oct 19, 19 87 that (I) (we) last saw the deceased alive on Oct 19, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| Kai-Yiu Yeung MD | ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ] | 10-26-87 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| Dr. Kai Yiu Yeung | Suite 201 8926 Woodyard Rd., Clinton, Md. 20735 |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN | COUNTY | STATE |
|---|---|---|---|---|---|
| Burial | 10-28-87 | Trinity Memorial | Waldorf | Chas | Md. |

| 24. FUNERAL DIRECTOR NAME | ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| Huntt Funeral Home | P. O. Box 156 Waldorf, Md. 20601 | OCT 28 1987 | |

068272 OCT 13 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR — REG NO 2 9 5 8 3

| 1. DECEASED NAME (TYPE OR PRINT) FIRST | MIDDLE | LAST |
|---|---|---|
| MARK | ANTHONY | REVENE |

2a. DATE OF DEATH: KNOWN [X] ESTIMATED [ ] — MONTH 10 DAY 7 YEAR 1987 — 2b. HOUR M

| 3. SEX | 4. RACE | 5. DATE OF BIRTH (MONTH DAY YEAR) | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YR (MONTHS / DAYS) | IF UNDER 24 HRS (HOURS / MIN) | 2c. DATE PRONOUNCED DEAD (MONTH DAY YEAR) | 2d. HOUR |
|---|---|---|---|---|---|---|---|
| Male | Cauc. | Dec 12 1962 | 24 YRS | | | 10 7 1987 | 12:50 AM |

| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. BALTIMORE CITY OR COUNTY OF DEATH |
|---|---|---|---|
| California | U.S.A. | | Charles County MD |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| La Plata | Physicians Memorial Hospital | Mechanic | Oil Co. |

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| Maryland | Charles | Waldorf | YES [ ] NO XX | 2409 York Court / 20601 |

| 14. FATHER'S NAME FIRST MIDDLE LAST | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST |
|---|---|
| Donald Revene | Patricia Ann Ellyson |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO | 17. INFORMANT (Wife) ADDRESS |
|---|---|---|---|
| Yes | 1981-1982 | 448-74-7166 | Monica Ann Revene -Same as #13- |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Gunshot wound of abdomen (handgun)
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? |
|---|---|---|
| | | YES [X] NO [ ] |

| 21a. EXTERNAL CAUSE WAS | 21b. TIME OF INJURY (HOUR MONTH DAY YEAR) | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |
|---|---|---|
| UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH | 10:35 AM 10-6- 1987 | Subject shot by police. |

| 21d. INJURY OCCURRED | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |
|---|---|---|
| WHILE AT WORK [ ] NOT WHILE AT WORK [X] | street | 2409 York Ct., Waldorf / Charles / MD |

22a. I certify that I took charge of the remains described above, held on Autopsy [X], Inspection [ ], Inquiry [ ] and in my opinion death resulted from: Natural causes [ ], Accident [ ], Suicide [ ], Homicide [X], Undetermined manner [ ].

ACTUAL SIGNATURE _____ M.D. TITLE (SPECIFY) Deputy Chief MEDICAL EXAMINER — DATE SIGNED 10-7-87

EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D. — ADDRESS 111 Penn St., Balto., MD 21201

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| Burial | 10/10/87 | Trinity Mem Gardens | Waldorf, Charles, Md. |

| 24. FUNERAL DIRECTOR NAME | ADDRESS | 25a. DATE REC'D BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| Huntt Funeral Home | P.O.Box 156 Waldorf, Md 20601 | OCT 09 1987 | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM DH-3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84 25M BP

DHMH - 17 (VR A15 ME (5))

070109 OCT 29 '87

FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 29580

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon sheets. Page 4 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

| | | | | |
|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: Revie | MIDDLE: Johova | LAST: Rigby | 2a. DATE OF DEATH MONTH: October DAY: 21 YEAR: 1987 | 2b. HOUR: 9:21 A.M. |
| 3. SEX: Male | 4. RACE: White | 5. DATE OF BIRTH MONTH: 06 DAY: 19 YEAR: 1925 | 6. AGE (IN YEARS LAST BIRTHDAY): 62 YRS | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 1 DAY: HOURS / MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Georgia | 7b. CITIZEN OF WHAT COUNTRY?: U. S. Of A. | 8. MARRIED XX NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: Charles County, MD. | |
| 10. CITY OR TOWN OF DEATH: LaPlata | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Physicians Memorial Hospital | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Terminal Cntrl.Man. | 12b. KIND OF BUSINESS OR INDUSTRY: Ryder Trucking | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland | 13b. COUNTY: Charles | 13c. CITY OR TOWN: Indian Head | 13d. INSIDE CITY LIMITS? YES ☐ NO XX | 13e. STREET ADDRESS / ZIP CODE: 22 G Riverview Village ZIP:20640 |
| 14. FATHER'S NAME FIRST: Turner | MIDDLE: Critten | LAST: Rigby | 15. MOTHER'S MAIDEN NAME FIRST: Sarah | MIDDLE: Elizabeth LAST: Harrell |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): Yes (IF YES, GIVE WAR OR DATES): W.W.II | 16b. SOCIAL SECURITY NO.: 257-36-9726 | 17. INFORMANT: Nita H. Rigby, Indian Head,Md.20640 | ADDRESS: 22 G Riverview V. | |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CARDIOGENIC SHOCK
DUE TO, OR AS A CONSEQUENCE OF (b): ACUTE MYO CARDIAL INFARCTION
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) ☐ | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE | |

22a. I certify that (I) (this hospital) attended the deceased from 10/17/ 19 87 to 10/21/ 19 87, that (I) (we) last saw the deceased alive on 10/20/ 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Ramakrishna — DEGREE: ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED:

22d. PHYSICIAN'S NAME (TYPE OR PRINT): N. Ramakrishna M.D.

22e. ADDRESS: Waldorf, Maryland 20601

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial | 23b. DATE: 10/24/87 | 23c. NAME OF CEMETERY OR CREMATORY: Riverside Mem.Park | 23d. LOCATION CITY OR TOWN / COUNTY / STATE: Jacksonville,Duval,Fla. | |
| 24. FUNERAL DIRECTOR NAME / ADDRESS: Arehart Funeral Home, Inc.,La Plata,Md. | 25a. DATE REC'D. BY REGISTRAR: OCT 26 1987 | 25b. REGISTRAR'S SIGNATURE | | |

Q70063 OCT 29 87

FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 29581

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
**TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1. DECEASED NAME (TYPE OR PRINT): Theodore O. Saunders, Jr.
2a. DATE OF DEATH: KNOWN [X] ESTIMATED [ ] 10-22 1987
2b. HOUR: M
2c. DATE PRONOUNCED DEAD: 10-22 1987
2d. HOUR: 4:45 P M
3. SEX: M
4. RACE: B
5. DATE OF BIRTH: 12-04-1940
6. AGE (IN YEARS LAST BIRTHDAY): 46 YRS
IF UNDER 1 YR: MONTHS / DAYS
IF UNDER 24 HRS: HOURS / MIN
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): DC
7b. CITIZEN OF WHAT COUNTRY?: USA
8. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]
9. BALTIMORE CITY OR COUNTY OF DEATH: Charles County MD
10. CITY OR TOWN OF DEATH: La Plata
11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Physician's Memorial Hospital
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): MAIL HANDLER
12b. KIND OF BUSINESS OR INDUSTRY: US P.O.

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: D.C.
13b. COUNTY:
13c. CITY OR TOWN: WASHINGTON
13d. INSIDE CITY LIMITS? YES [X] NO [ ]
13e. STREET ADDRESS: 317 EMERSON ST., N.W.

14. FATHER'S NAME: THEODORE O. SAUNDERS, SR.
15. MOTHER'S MAIDEN NAME: LOUISE K. WHITING
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): NO
(IF YES, GIVE WAR OR DATES):
16b. SOCIAL SECURITY NO.: 579-54-9844
17. INFORMANT: ANITA BROOKS-SISTER
ADDRESS: 317 Emerson St., N.W.D.C. SAME AS ABOVE

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Head and neck injuries
DUE TO, OR AS A CONSEQUENCE OF (b):
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
8120
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a.

19a. DATE OF OPERATION:
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?:
20. AUTOPSY? YES [X] NO [ ]

21a. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR: 3:20PM 10-22, 87
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2): Driver in auto/auto collision
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.): road
21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE: East on Rt. 257, South Butler road, Newburg, Charles County, MD

22a. I certify that I took charge of the remains described above, held an Autopsy [X] Inspection [ ] Inquiry [ ] and in my opinion death resulted from Natural causes [ ] Accident [X] Suicide [ ] Homicide [ ] Undetermined manner [ ]

ACTUAL SIGNATURE: Charles P. Kokes
M.D. TITLE (SPECIFY): Assistant MEDICAL EXAMINER
DATE SIGNED: 10-23-87
EXAMINER'S NAME (TYPE OR PRINT): Charles P. Kokes, M.D.
ADDRESS: 111 Penn Street, Baltimore, MD 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL
23b. DATE: 10-28-87
23c. NAME OF CEMETERY OR CREMATORY: MT. OLIVET
23d. LOCATION CITY OR TOWN / COUNTY / STATE: WASHINGTON, D.C.
24. FUNERAL DIRECTOR NAME / ADDRESS: ALEXANDER S. POPE 2617 PENNA., AVE., S.E.
25a. DATE REC'D BY REGISTRAR: OCT 28 1987
25b. REGISTRAR'S SIGNATURE: Julia Davidson-Perdue

Oct 84 25M BP
DHMH 47
(VR A15 ME (5))

070387 NOV -2 87

FOR 1 - STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

87 29 88

REG NO

DIVISION OF VITAL RECORDS, 201 W PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the informant, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the local registrar within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury or other traumatic event, the medical examiner must be notified and consulted.

| | | | | |
|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: Frances | MIDDLE | LAST: Scott | 2a. DATE OF DEATH MONTH/DAY/YEAR: 10/25/87 | 2b. HOUR: 6:15 PM |
| 3. SEX: F | 4. RACE: W | 5. DATE OF BIRTH MONTH/DAY/YEAR: 9/5/24 | 6. AGE (IN YEARS LAST BIRTHDAY): 63 YRS | IF UNDER 1 YEAR: DAYS / HOURS / MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Baltimore Md. | 7b. CITIZEN OF WHAT COUNTRY?: US | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: Charles MD. | |
| 10. CITY OR TOWN OF DEATH: La Plata | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Meridian Nursing Center | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): | 12b. KIND OF BUSINESS OR INDUSTRY: |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS / ZIP CODE |
|---|---|---|---|---|
| MD | Calvert | Huntingtown | YES ☐ NO ☒ | 3224 Solomons Island Rd. 20639 |

| 14. FATHER'S NAME FIRST / MIDDLE / LAST | 15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST |
|---|---|
| Edward Warren | Sarah R. Hickey |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO | 17. INFORMANT ADDRESS |
|---|---|---|---|
| NO | N/A | 219-12-5775 | Donald Scott, 5731 Denfield Rd, Rockville, Md |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for a, b, and c.)

PART I. DEATH WAS CAUSED BY

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Cardiopulmonary arrest | — |
| DUE TO, OR AS A CONSEQUENCE OF (b) | Pulmonary edema | 2 hours |
| DUE TO, OR AS A CONSEQUENCE OF (c) | Congestive heart failure | 10 days |

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Metastatic Breast Cancer

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) |
|---|---|---|
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |

22a. I certify that (I) this hospital) attended the deceased from Oct. 23 19 87 to Oct. 25 19 87 that (I) we) last saw the deceased alive on Oct. 23 19 87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | | 22c. DATE SIGNED |
|---|---|---|---|
| B Larry Jenkins | MD | ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 10/25/87 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| B Larry Jenkins MD | Pembrooke Square Waldorf, Maryland |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| Burial | 10/28/1987 | Emmanuel Meth. Ch. | Huntingtown, Calvert, Maryland |

| 24. FUNERAL DIRECTOR NAME / ADDRESS | 25a. DATE REC'D BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| Donald V. Borgwardt Rt 264, Box 34B, Port Republic, Maryland 20676 | OCT 30 1987 | Julia Davison-Sanders |

BP_____

DHMH - 16 60M 7/84 (VRA 15, 4)

069686 OCT 26 '87

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO 29387

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. **TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07-84 25M BP

DHMH - 17 (VR A15 ME (5))

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: MICHAEL | MIDDLE: E | LAST: THEIS | 2a. DATE OF DEATH KNOWN X / ESTIMATED ☐: 10-16-87 | 2b. HOUR: M | | |
| 3. SEX: MALE | 4. RACE: CAUCASIAN | 5. DATE OF BIRTH: MONTH 2 DAY 3 YEAR 1963 | 6. AGE (IN YEARS LAST BIRTHDAY): 24 YRS. | IF UNDER 1 YR: MONTHS / DAYS | IF UNDER 24 HRS: HOURS / MIN | 2c. DATE PRONOUNCED DEAD: 10-16-87 | 2d. HOUR: 11PM M |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): CALIFORNIA | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED ☐ NEVER MARRIED X WIDOWED ☐ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: CHARLES MD | | | | |
| 10. CITY OR TOWN OF DEATH: LaPlata | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Physicians Memorial Hospital | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): SALES | 12b. KIND OF BUSINESS OR INDUSTRY: DEPT STORE | | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: VIRGINIA | 13b. COUNTY: FAIRFAX | 13c. CITY OR TOWN: VIENNA | 13d. INSIDE CITY LIMITS? YES ☐ NO X | 13e. STREET ADDRESS: 8003 TYSON OAK CIRCLE | | | |
| 14. FATHER'S NAME FIRST: WARREN | MIDDLE: A | LAST: THEIS | 15. MOTHER'S MAIDEN NAME FIRST: KAREN | MIDDLE | LAST: PETERSON | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): NO | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO.: 230-17-9410 | 17. INFORMANT: MOTHER/ | ADDRESS: 8516 BOUND BROOK LN ALEXANDRIA, VA 22309 | | | |

**MEDICAL CERTIFICATION**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Gunshot wound of head

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b):

DUE TO, OR AS A CONSEQUENCE OF (c):

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a.

| | | |
|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? YES XX NO ☐ |
| 21a. EXTERNAL CAUSE WAS UNDERLYING X OR CONTRIBUTING ☐ CAUSE OF DEATH | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR: 6PM P.M. 10-16-87 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2): self/inflicted |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK X | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.): in an aircraft | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE: Potomac River nr. Naval Station Indian Head, Maryland |

22a. I certify that I took charge of the remains described above, held an Autopsy [X] Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural causes ☐ Accident ☐ Suicide [X] Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Margarita A. Korell M.D. TITLE (SPECIFY): Assistant MEDICAL EXAMINER DATE SIGNED: 10-17-87

EXAMINER'S NAME (TYPE OR PRINT): Margarita A. Korell, M.D. ADDRESS: 111 Penn Street

| | | | |
|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY): CREMATION | 23b. DATE: 10/19/87 | 23c. NAME OF CEMETERY OR CREMATORY: LEE CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE: CLINTON, MARYLAND |
| 24. FUNERAL DIRECTOR NAME / ADDRESS: DEMAINE FUNERAL HOMES, INC ALEXANDRIA, VA22314 | 25a. DATE REC'D BY REGISTRAR: OCT 23 1987 | 25b. REGISTRAR'S SIGNATURE: [signature] | |

068242 OCT 87

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1- FOR STATE REGISTRAR

REG NO 29590

1. DECEASED NAME (TYPE OR PRINT): FIRST Charles MIDDLE M. Hen LAST Thompson

2a. DATE KNOWN OF DEATH ☒ ESTIMATED ☐ MONTH 10 DAY 4 YEAR 1987 — 2b. HOUR 11:18 AM

3. SEX M — 4. RACE W — 5. DATE OF BIRTH MONTH 4 DAY 4 YEAR 31 — 6. AGE (IN YEARS LAST BIRTHDAY) 56 YRS. — IF UNDER 1 YR. MONTHS DAYS — IF UNDER 24 HRS. HOURS MIN

2c. DATE PRONOUNCED DEAD MONTH 10 DAY 4 YEAR 1987 — 2d. HOUR 11:18 AM

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kentucky — 7b. CITIZEN OF WHAT COUNTRY? USA — 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒ — 9. BALTIMORE CITY OR COUNTY OF DEATH Charles County MD

10. CITY OR TOWN OF DEATH LaPlata — 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN HOSPITAL, GIVE STREET ADDRESS) Physicians Memorial Hospital — 12a. USUAL OCCUPATION (TYPE OF WORK DONE DURING MOST OF WORKING LIFE) Crane Oper. — 12b. KIND OF BUSINESS OR INDUSTRY Construction

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE Maryland — 13b. COUNTY Charles — 13c. CITY OR TOWN Indian Head — 13d. INSIDE CITY LIMITS? YES ☐ NO ☐ — 13e. STREET ADDRESS 5 North First Street 20640

14. FATHER'S NAME FIRST George MIDDLE Washington LAST Thompson

15. MOTHER'S MAIDEN NAME FIRST Myrtle MIDDLE Adams

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes — (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO. 235 42 4968

17. INFORMANT Catherine Eastwood — ADDRESS Same as #13

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Coronary artery disease — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Years

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

19a. DATE OF OPERATION — 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? — 20. AUTOPSY? YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH — 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 — 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ — 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) — 21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE H.M. Heft M.D. — TITLE (SPECIFY) Charles Co MEDICAL EXAMINER — DATE SIGNED 10/4/87

EXAMINER'S NAME (TYPE OR PRINT) H.M. Heft MD — ADDRESS 1020 Davis Dr. LaPlata Md 20646

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial — 23b. DATE 9Oct1987 — 23c. NAME OF CEMETERY OR CREMATORY Woodmere Cemetery — 23d. LOCATION CITY OR TOWN Huntington COUNTY West Va. STATE

24. FUNERAL DIRECTOR NAME Robert E Wilhelm Funeral Home ADDRESS Suitland Maryland

25a. DATE REC'D. BY REGISTRAR OCT 8 1987 — 25b. REGISTRAR'S SIGNATURE Julia Davidson-Landers

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM DHMH 5. RETAIN PAGE 5 FOR YOUR FILES.

**TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH 17 (VR A15 ME (5)) 20M 4/82

068420 OCT 14 87

FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 87 29591

| 1. DECEASED NAME (TYPE OR PRINT) First | Middle | Last | 2a. DATE OF DEATH Month Day Year | 2b. HOUR |
|---|---|---|---|---|
| Helen | | Thompson | October 6, 1987 | 9:50 A.M. |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH Month Day Year | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR Months / Days | IF UNDER 1 DAY Hours / Min. |
|---|---|---|---|---|---|
| FEMALE | BLACK | APRIL 12, 1937 | 50 YRS | | |

| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH |
|---|---|---|---|
| MARYLAND | UNITED STATES | | Charles County, MD |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK DONE MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| LaPlata | Physicians Memorial Hospital | NONE | — |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 11a. STATE | 11b. COUNTY | 11c. CITY OR TOWN | 11d. INSIDE CITY LIMITS? | 11e. STREET ADDRESS / ZIP CODE |
|---|---|---|---|---|
| MARYLAND | PRINCE GEO. | BRANDYWINE | YES ☐ NO ☒ | ROUTE 1 Box 288/ 20613 |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| BENNIE | | REED | MARY | | MEREDITH |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| NO | | 219-36-8454 | EMMA THOMPSON | 5005 LeeJay Drive Hillside, Md. 20743 |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac arrest
DUE TO, OR AS A CONSEQUENCE OF (b) Short bowel syndrome
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |
|---|---|---|
| | | |

22a. I certify that (I) (this hospital) attended the deceased from 10/4/87, 19____, to 10/6/87, 19____, that (I) (we) last saw the deceased alive on 10/6/87, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| Robert Timothy Pace M.D. | ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| Robert Timothy Pace M.D. | Waldorf, Maryland 20601 |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN | COUNTY | STATE |
|---|---|---|---|---|---|
| BURIAL | 10-10-87 | ST. JOSEPH | POMFRET | CHARLES | MD. |

| 24. FUNERAL DIRECTOR NAME | ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| THORNTON FUNERAL HOME | POMONKEY, MD | OCT 13 1987 | Donna Davidson-Rondeau |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked "yes," the State Medical Examiner must be notified immediately, and no action taken on the certificate pending his release of same.

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

071271 NOV 10 87

Item 18a,b, 22a 0633 11-5-87 dw

FOR STATE REGISTRAR per med exam

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 29592

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
**TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1. DECEASED NAME (TYPE OR PRINT): Robert M. Venables

2a. DATE OF DEATH: KNOWN ☒ ESTIMATED ☐ 8-27-87 — 2b. HOUR: M

3. SEX: M — 4. RACE: W — 5. DATE OF BIRTH: Sept 19 49 — 6. AGE (IN YEARS, LAST BIRTHDAY): 37 YRS. — IF UNDER 1 YR. (MONTHS, DAYS) — IF UNDER 24 HRS. (HOURS, MIN.)

2c. DATE PRONOUNCED DEAD: 8-27-87 — 2d. HOUR: 11:45 a M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Salisbury, Md.

7b. CITIZEN OF WHAT COUNTRY? USA

8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Charles County MD

10. CITY OR TOWN OF DEATH: La Plata

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Physician's Memorial Hospital

12a. USUAL OCCUPATION (TYPE OF WORK DONE DURING MOST OF WORKING LIFE): Musician

12b. KIND OF BUSINESS OR INDUSTRY: dance

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland — 13b. COUNTY: Charles — 13c. CITY OR TOWN: Waldorf — 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ — 13e. STREET ADDRESS: 3040 Heathcote Road 20601

14. FATHER'S NAME: H. Robert Venables

15. MOTHER'S MAIDEN NAME: Verna Weber Venables

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): No — (IF YES, GIVE WAR OR DATES): ---

16b. SOCIAL SECURITY NO.

17. INFORMANT — ADDRESS: Verna Venables Georgetown, De

**MEDICAL CERTIFICATION**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1 DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): FATTY LIVER

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:

DUE TO, OR AS A CONSEQUENCE OF (b): ALCOHOLISM

DUE TO, OR AS A CONSEQUENCE OF (c):

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a.

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY? YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f. LOCATION STREET — CITY OR TOWN — COUNTY — STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined Manner ☐

ACTUAL SIGNATURE: Dennis F. Smyth Jr. M.D. — TITLE (SPECIFY): Assistant MEDICAL EXAMINER — DATE SIGNED: 8/27/87

EXAMINER'S NAME (TYPE OR PRINT): Dennis F. Smyth, M.D. — ADDRESS: 111 Penn St.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial — 23b. DATE: 8-31-87 — 23c. NAME OF CEMETERY OR CREMATORY: Union Cemetery — 23d. LOCATION CITY OR TOWN: Georgetown — COUNTY: Sussex — STATE: De

24. FUNERAL DIRECTOR — NAME: William J. Eskam Jr — ADDRESS: Georgetown, Delaware

25c. DATE REC'D BY REGISTRAR: NOV 03 1987 — 25h. REGISTRAR'S SIGNATURE

07-84 25M 8P

DHMH - 17 (VR A15 ME (5))

069581 OCT 23 87

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

(5) 29593

1- FOR STATE REGISTRAR — REG. NO.

DECEDENT'S NAME (TYPE OR PRINT): FIRST Oscar MIDDLE Sylvester LAST Walls

2a. DATE OF DEATH: KNOWN [X] ESTIMATED [ ] MONTH 10 DAY 17 YEAR 1987 — 2b. HOUR 21 P 23 M

3. SEX: M — 4. RACE: B — 5. DATE OF BIRTH: MONTH 2 DAY 26 YEAR 41 — 6. AGE (IN YEARS LAST BIRTHDAY): 46 YRS. — IF UNDER 1 YR. MONTHS / DAYS — IF UNDER 24 HRS. HOURS / MIN

2c. DATE PRONOUNCED DEAD: MONTH 10 DAY 17 YEAR 1987 — 2d. HOUR 00 23 P M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Washington DC — 7b. CITIZEN OF WHAT COUNTRY? USA — 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] — 9. BALTIMORE CITY OR COUNTY OF DEATH: Charles County MD

10. CITY OR TOWN OF DEATH: Hughesville — 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN EACH FACILITY, GIVE STREET ADDRESS): Gallant Green Rd. — 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): — 12b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (OF DECEDENT (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)) — 20735

13a. STATE: MD — 13b. COUNTY: Prince George — 13c. CITY OR TOWN: Clinton — 13d. INSIDE CITY LIMITS? YES [ ] NO [X] — 13e. STREET ADDRESS: 7577 Surratts Rd

14. FATHER'S NAME: FIRST Clarence MIDDLE S. LAST Walls — 15. MOTHER'S MAIDEN NAME: FIRST Essie MIDDLE R. LAST Savoy

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): No (IF YES, GIVE WAR OR DATES) — 16b. SOCIAL SECURITY NO: 220-38-4955 — 17. INFORMANT: Apt. # 304 Mrs. Antoinette Walls — ADDRESS: 3605 Silver Hill Rd Suitland MD 20746

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Multiple Trauma
DUE TO, OR AS A CONSEQUENCE OF
(b):
DUE TO, OR AS A CONSEQUENCE OF
(c):

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).

19a. DATE OF OPERATION: — 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? — 20. AUTOPSY? YES [ ] NO [X]

21a. EXTERNAL CAUSE WAS: UNDERLYING [ ] OR CONTRIBUTING [X] CAUSE OF DEATH — 21b. TIME OF INJURY: HOUR A.M. 21 23 (M) MONTH 10 DAY 17 YEAR 1987 — 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2): Truck hit train

21d. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X] — 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.): Street — 21f. LOCATION: STREET Gallant Green Rd CITY OR TOWN Hughesville COUNTY Charles STATE MD

22a. I certify that I took charge of the remains described above, held an Autopsy [ ] Inspection [X] Inquiry [X] and in my opinion death resulted from: Natural causes [ ] Accident [X] Suicide [ ] Homicide [ ] Undetermined manner [ ]

ACTUAL SIGNATURE: David N Gingrick — M.D. TITLE (SPECIFY): Assistant MEDICAL EXAMINER — DATE SIGNED: 10/18/87

EXAMINER'S NAME (TYPE OR PRINT): David N. Gingrick MD — ADDRESS: 5019 Woodhaven Dr. LaPlata MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial — 23b. DATE: 21 Oct '87 — 23c. NAME OF CEMETERY OR CREMATORY: Union Bethel AME — 23d. LOCATION: CITY OR TOWN Brandywine COUNTY P.G.Co. STATE MD.

24. FUNERAL DIRECTOR: NAME Martell Adams ADDRESS Aquasco Md 20608 — 25a. DATE REC'D. BY REGISTRAR: OCT 22 1987 — 25b. REGISTRAR'S SIGNATURE: Julia Davidson Randall

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2 AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. SEE ITEM 24 PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 (PRIOR TO BURIAL, CREMATION, OR REMOVAL

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

BP

DHMH 17
(VR A15 ME (5))
20M 4/82

5
068824 OCT 16 87

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 29594

1. DECEASED NAME (TYPE OR PRINT): Joyce Virginia Wilmer

2a. DATE OF DEATH: KNOWN X, ESTIMATED ☐ — MONTH 10 DAY 9 YEAR 87

2b. HOUR: M

3. SEX: Female

4. RACE: White

5. DATE OF BIRTH: MONTH 06 DAY 14 YEAR 44

6. AGE (IN YEARS, LAST BIRTHDAY): 43 YRS. IF UNDER 1 YR: MONTHS DAYS IF UNDER 24 HRS: HOURS MIN

2c. DATE PRONOUNCED DEAD: MONTH 10 DAY 9 YEAR 87

2d. HOUR: 12:21 a M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Virginia

7b. CITIZEN OF WHAT COUNTRY? U.S.A.

8. MARRIED X NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Charles County, MD

10. CITY OR TOWN OF DEATH: La Plata

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Physician's Memorial Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Home maker

12b. KIND OF BUSINESS OR INDUSTRY: at Home

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland

13b. COUNTY: Charles

13c. CITY OR TOWN: Faulkner

13d. INSIDE CITY LIMITS? YES ☐ NO X

13e. STREET ADDRESS: South Faulkner Rd., Box222

28632

14. FATHER'S NAME: Joseph Richard Martin

15. MOTHER'S MAIDEN NAME: Gladys Virginia Fincham

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): No (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 231-58-7614

17. INFORMANT: Joseph A. Wilmer -Husband ADDRESS: Same as # 13.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

IMMEDIATE CAUSE (a): Blunt Trauma to Chest

DUE TO, OR AS A CONSEQUENCE OF (b):

DUE TO, OR AS A CONSEQUENCE OF (c):

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I a

19a. DATE OF OPERATION:

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY? YES X NO ☐

21a. EXTERNAL CAUSE WAS: UNDERLYING X OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY: HOUR A.M. 11:25 PM MONTH 10 DAY 8 YEAR 87

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2): driver of auto/fixed object impact

21d. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK X

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.): roadway

21f. LOCATION: STREET Rt. 301 CITY OR TOWN Faulkner COUNTY Charles STATE Md.

22a. I certify that I took charge of the remains described above, held an Autopsy X, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident X, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE: Dennis F. Smyth M.D. TITLE (SPECIFY): Assistant MEDICAL EXAMINER DATE SIGNED: 10/9/87

EXAMINER'S NAME (TYPE OR PRINT): Dennis F. Smyth, M.D. ADDRESS: 111 Penn St., Balto., Md. 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 10/12/87

23c. NAME OF CEMETERY OR CREMATORY: Mt. Rest Cemetery

23d. LOCATION: CITY OR TOWN La Plata, COUNTY Charles, STATE Maryland

24. FUNERAL DIRECTOR: NAME AND ADDRESS: Arehart Funeral Home, Inc, La Plata, Md.

25a. DATE REC'D BY REGISTRAR: OCT 15 1987

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, (2) AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 6-3. SEE PAGE 5 FOR YOUR FILES.

**TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

**DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201**

07/84 25M BP

DHMH - 17 (VR A15 ME (5))

69578 OCT 23 87

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 29595

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with [illegible] hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked on Item 18 above, other traumatic event the medical examiner must be notified not later

| | | | | | |
|---|---|---|---|---|---|
| 1 DECEASED NAME (TYPE OR PRINT): Frances Isabelle Wynn / Frances I Wynn | | | | 2a DATE OF DEATH: MONTH 10 DAY 19 YEAR 87 | 2b HOUR: 6 10 AM |
| 3 SEX: Female | 4 RACE: Caucasian | 5 DATE OF BIRTH: MONTH 12 DAY 18 YEAR 1904 | 6 AGE (IN YEARS LAST BIRTHDAY): 82 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 1 HR.: HOURS / MIN. |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY): Washington D.C. U.S.A. | 7b CITIZEN OF WHAT COUNTRY?: USA | 8 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ | 9 BALTIMORE CITY OR COUNTY OF DEATH: Charles MD | | |
| 10 CITY OR TOWN OF DEATH: La Plata | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Physicians Memorial Hosp | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Sales Clerk | 12b KIND OF BUSINESS OR INDUSTRY: Retail Stor | |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a STATE | 13b COUNTY | 13c CITY OR TOWN | 13d INSIDE CITY LIMITS? | 13e STREET ADDRESS / ZIP CODE |
|---|---|---|---|---|
| Dist. of Col. | | Washington | YES ☒ NO ☐ | 2006 Naylor Rd., SE/20020 |

| 14 FATHER'S NAME (FIRST MIDDLE LAST) | 15 MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) |
|---|---|
| Frederick Wynn | unavailable |

| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b SOCIAL SECURITY NO. | 17 INFORMANT | ADDRESS |
|---|---|---|---|---|
| no | --- | 577-07-3647 | Douglas Johnson | Apt. 228, Box 153 Waldorf, Md. 20601 |

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Respiratory arrest | |
| DUE TO, OR AS A CONSEQUENCE OF (b) | Respiratory insufficiency | 10 days |
| DUE TO, OR AS A CONSEQUENCE OF (c) | Chronic Obstructive Pulmonary Disease | years |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a DATE OF OPERATION | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a AUTOPSY? YES ☐ NO ☐ | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
|---|---|---|---|
| | | | |

| 21a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |
|---|---|---|
| 21d INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f LOCATION: STREET, CITY OR TOWN, COUNTY, STATE |

22a I certify that (I) (this hospital) attended the deceased from Oct. 15, 19 87, to Oct. 19, 19 87, that (I) (we) last saw the deceased alive on Oct. 19, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| 22b SIGNATURE | DEGREE | 22c DATE SIGNED |
|---|---|---|
| B Larry Jenkins Jr MD | ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 10/19/87 |

| 22d PHYSICIAN'S NAME (TYPE OR PRINT) | 22e ADDRESS |
|---|---|
| B Larry Jenkins Jr MD | |

| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b DATE | 23c NAME OF CEMETERY OR CREMATORY | 23d LOCATION: CITY OR TOWN, COUNTY, STATE |
|---|---|---|---|
| Burial | 10-22-87 | Cedar Hill Cem. | Suitland Pr. Geo. Md. |

| 24 FUNERAL DIRECTOR (NAME) | ADDRESS | 25a DATE REC'D BY REGISTRAR | 25b REGISTRAR'S SIGNATURE |
|---|---|---|---|
| Huntt Funeral Home | P. O. Box 156 Waldorf, Md. 20601 | OCT 22 1987 | Julia Davidson-Randall |

BP

DHMH - 16 60M 7/84
(VRA 15, 4)